United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center

Dates of Onsite Review: July 26th to July 30th, 2017

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with intellectual and developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers the 12 State Supported Living Centers (SSLCs), Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio, and the Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

In 2009, the parties selected three Independent Monitors, each of whom was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that were submitted to the parties. Each Monitor engaged an expert team for the conduct of these reviews.

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures.

Given the intent of the parties to focus upon outcomes experienced by individuals, some aspects of the monitoring process were revised, such that for a group of individuals, the Monitoring Teams' reviews now focus on outcomes first. For this group, if an individual is experiencing positive outcomes (e.g., meeting or making progress on personal goals), a review of the supports provided to the individual will not need to be conducted. If, on the other hand, the individual is not experiencing positive outcomes, a deeper review of the way his or her protections and supports were developed, implemented, and monitored will occur. In order to assist in ensuring positive outcomes are sustainable over time, a human services quality improvement system needs to ensure that solid protections, supports, and services are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

In addition, the parties agreed upon a set of five broad outcomes for individuals to help guide and evaluate services and supports. These are called Domains and are included in this report.

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of

the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

In order to assess the facility's compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities:

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Summary:** The Monitors have provided a summary of the facility's performance on the indicators in the outcome, as well as a determination of whether each indicator will move to the category of requiring less oversight or remain in active monitoring.
d. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
f. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

At the beginning of each Domain, the Monitors provide a brief synopsis of the findings. These summaries are intended to point the reader to additional information within the body of the report, and to highlight particular areas of strength, as well as areas on which Center staff should focus their attention to make improvements.

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Denton SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

Domain #1: The State will make reasonable efforts to ensure that individuals in the Target Population are safe and free from harm through effective incident management, risk management, restraint usage and oversight, and quality improvement systems.

This Domain currently contains 22 outcomes and 60 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, and mortality review. At the time of the last review, 13 of these indicators, including three entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, no additional indicators will move to the category of less oversight. One indicator, which represents the entirety of Outcome 4 in the area of abuse, neglect, and incident management, will return to active oversight.

With the agreement of the parties, the Monitors have largely deferred the development and monitoring of quality improvement outcomes and indicators to provide the State with the opportunity to redesign its quality improvement system. Additional outcomes and indicators will be added to this Domain during upcoming rounds of reviews.

The identification and management of risk is an important part of protection from harm. Risk is also monitored via a number of outcomes and indicators in the other four domains throughout this report. These outcomes and indicators may be added to this domain or cross-referenced with this domain in future reports.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

<u>Restraint</u>
Overall, usage of crisis intervention restraint at Denton SSLC remained low and stable. There were no occurrences of crisis intervention chemical restraint and a few of crisis intervention mechanical restraint. The facility, however, did not submit a full set of data to allow the Monitoring Team to do a typical review and commentary on the overall management of crisis intervention restraint at the facility.

Crisis intervention physical restraints were handled and documented correctly, but other types of restraint (e.g., crisis intervention mechanical, PMR-SIB, medical restraint) were not handled and documented correctly. This points to the need for the facility to focus upon making sure these other types of restraints receive proper implementation, documentation, review, and actions, when needed.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; specifically indicating

whether or not any injuries occurred as a result of the restraint; and completing necessary documentation for mechanical restraint.

Abuse, Neglect, and Incident Management

For all cases (except one), supports were in place to have reduced the likelihood of the incident occurring (i.e., indicator 1). Some individuals were placed on the streamlined caller/investigation list. The facility, however, was not following the DADS protocol/policy (e.g., Individual #459).

Some basic protections were not evident, such as ensuring reporting was done correctly (for three investigations), staff could verbally state reporting requirements (for the one individual for whom this was assessed), that reporting posters were readily visible (for seven of the individuals), and re-assignment of alleged perpetrators (for five of the investigations).

Most investigations were not completed within the required 10-day time period. Extension documentation did not describe extraordinary circumstances.

Most UIRs were written in a way that made it hard to follow the story of the incident. There was a lot of disjointed information, and they did not read like an investigation. Some technical assistance on this, or perhaps models from some of the other Centers may be helpful to Denton SSLC.

Investigations all contained recommendations. The facility continued its excellent process for tracking recommendations to completion and collecting the evidence to validate completion. It included a final review by the facility's assistant independent ombudsman.

Denton SSLC continued to regularly collect and review relevant incident- and allegation-related data. This was good to see and sets the occasion for ongoing quality improvement. Given the many performance improvements needed in incident management, likely some corrective actions should have been identified.

Other

IDTs were discussing the need for pretreatment sedation for dental procedures, including some discussion of desensitization strategies with help from the specialty behavior analysis clinic on campus. However, none of these were implemented and no follow-up was evidenced.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.

Summary: Overall, usage of crisis intervention restraint at Denton SSLC remained low and stable. There were no occurrences of crisis intervention chemical restraint and a few occurrences of crisis intervention mechanical restraint. The facility, however, did not submit a full set of data to allow the Monitoring Team to do a typical review and commentary on the overall review and management of crisis intervention restraint at the facility. There was an active quality review of restraint usage at QAQI Council and other forums. It may be that the new electronic data record competed with pulling together the data sets requested. However, that being said, these are data sets that the facility itself needs to have in order to manage restraint usage. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	33% 4/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	60% 6/10	1/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data were requested from the facility for the past nine months (August 2016 through April 2017). Not all sets of data were provided. Based on what was provided, overall, usage of crisis intervention restraint at Denton SSLC remained low, that is, the rate was stable compared with the last review's already low rate. The use of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint and the average duration of a crisis intervention physical restraint continued to decrease, to just about six minutes. Additional attention to reduce this duration is needed, however, it was good to see that there was a decreasing trend across the past three review periods. There were no occurrences of crisis intervention chemical restraint and a few occurrences of crisis intervention mechanical restraint for two individuals. The facility should ensure that the use of mechanical devices at Denton SSLC is properly classified as PMR-SIB, crisis intervention mechanical restraint, or medical restraint.

There were a lot of injuries reported during crisis intervention restraint implementation. The data set graph showed 23 in the nine-month review period, and the tier 1 document .18 showed 42 in a six-month period. After the onsite week, the facility reported that these data were erroneous and included a count of restraints with no injury as well as with injury. This should be fixed because it is important to know the trend, if any, in injuries that occur during, and/or as a result of, restraint implementation.

The Center did not provide all of the requested data sets (e.g., use of crisis intervention mechanical restraint, number of individuals who had crisis intervention restraint implemented, use of PMR-SIB, the four data sets regarding restraint and medication usage for medical and dental procedures). This was a change from the last review, when a full set of data was provided.

Thus, facility data showed low/zero usage and/or decreases in four of the 12 facility-wide measures (overall use of crisis intervention restraint, use of crisis intervention physical and chemical restraint, duration of physical restraint)

The facility had an active restraint reduction committee. It met once per month and reviewed data, discussed specific individuals, and put action steps into place. An active restraint reduction committee can play an important role in affecting the overall usage of restraint at a facility.

Denton SSLC regularly reviewed restraint usage data at QAQI Council and also at Trend Analysis meetings. The narratives pointed to various data trend change and also to challenges with data collection and usage of the electronic health record system. This active review likely contributed to the low usage of crisis intervention restraint at the facility. It is also possible that the challenges with the electronic health record system contributed to some data sets not being submitted for this review and/or for some of the data sets to have what looked like inaccurate data.

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, the Monitoring Team reviewed restraint incidents for one additional individual (Individual #41) for a total of six individuals. Three received crisis intervention physical restraints (Individual #109, Individual #459, Individual #202), one received crisis intervention mechanical restraint (Individual #173), two received medical restraint (Individual #173, Individual #134), and one received PMR-SIB (Individual #41). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for two (Individual #134, Individual #41). The other four individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.

Summary: None of these basic restraint-related indicators had acceptable scores for all of the restraints. To be more specific, crisis intervention physical restraints were handled and documented correctly, but other types (crisis intervention mechanical, PMR-SIB, medical restraint) were not handled and documented correctly. This points to the need for the facility to focus upon making sure these other types of restraints receive proper implementation, documentation, review, and actions, when needed (i.e., proper management of restraint). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	109	459	173	202	134	41			
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to	60%	1/1	1/1	0/1	1/1	N/A	0/1			

	him/herself or others.	3/5									
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	60% 3/5	1/1	1/1	0/1	1/1	N/A	0/1			
7	There was no injury to the individual as a result of implementation of the restraint.	57% 4/7	1/1	1/1	1/2	1/1	0/1	0/1			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/4	0/1	0/1	0/1	0/1	Not rated	Not rated			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	86% 6/7	1/1	1/1	2/2	1/1	1/1	0/1			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	50% 3/6	0/1	1/1	1/1	0/1	0/1	1/1			

Comments:
The Monitoring Team chose to review seven restraint incidents that occurred for six different individuals (Individual #109 Individual #459, Individual #173, Individual #202, Individual #134, Individual #41). Of these, two were crisis intervention physical restraints, two were crisis intervention mechanical restraints or PMR-SIB, and two were medical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5-7 and 10. The facility met criteria for the two crisis intervention physical restraints. For the other four (crisis intervention mechanical, PMR-SIB, medical restraint), one or more of the four did not meet each of these four indicators. This points to the need for the facility to focus upon making sure these other types of restraints receive proper implementation, documentation, review, and actions, when needed (i.e., proper management of restraint).

9. Because criterion for indicator #2 was met for two of the individuals, this indicator was not rated for them. For the other four, there were one or more assessments that were not updated, PBSPs were more than a year old, and/or they were infrequently engaged in activities.

11. For three individuals, the ISP IRRF section did not have the proper information regarding possible contraindications (or statement that there were no contraindications) for the use of restraint.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	459	173	202	134	41			

12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	40% 2/5	1/1	1/1	0/1	0/1	0/1	Not rated			
Comments: 12. Because criteria for indicators 2-11 were met for one individual, this indicator was not scored for her. Some staff for three of the other individuals were unable to correctly answer some of the Monitoring Team's questions.											

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: As noted above in outcome 2, Denton SSLC did not correctly manage or document crisis intervention mechanical, PMR-SIB, and medical restraint usage. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	459	173	202	134	41			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	40% 2/5	1/1	0/1	0/1	1/1	N/A	0/1			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	25% 1/4	N/A	N/A	1/2	N/A	0/1	0/1			
Comments: 13-14. See comment in Summary box above.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; specifically indicating whether or not any injuries occurred as a result of the restraint; and completing necessary documentation for mechanical restraint. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	459	41	202	173	134			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	14% 1/7	0/1	0/1	0/1	1/1	0/2	0/1			
b.	The licensed health care professional documents whether there are	57%	0/1	1/1	0/1	1/1	2/2	0/1			

	any restraint-related injuries or other negative health effects.	4/7									
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	43% 3/7	0/1	0/1	0/1	1/1	2/2	0/1			

Comments: The crisis intervention restraints reviewed included those for: Individual #109 on 1/15/17 at 11:38 a.m.; Individual #459 on 4/13/17 at 7:37 a.m.; Individual #41 on 4/20/17 at 12:50 a.m. (mechanical restraint – helmet); Individual #202 on 2/22/17 at 9:45 a.m.; Individual #173 on 1/4/17 at 10:34 a.m. (mechanical restraint), and 4/30/17 from 6:00 a.m. to 6:00 p.m. for long-term use of medical restraint for an open wound on the individual's forehead; and Individual #173 on 1/4/17 at 10:34 a.m. for a glove for short-term medical restraint for healing of a wound caused by self-injurious behavior (SIB).

a. For four of the seven crisis intervention restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #41 on 4/20/17 at 12:50 a.m., Individual #173 on 1/4/17 at 10:34 a.m., and Individual #173 on 1/4/17 at 10:34 a.m.

For four of the seven restraints, nursing staff monitored and documented vital signs. The exceptions were for:

- For Individual #41, the Center provided documentation in response to the Monitoring Team's request stating: "[Individual #41]'s 4/20/2017 crisis mechanical restraint {helmet} checklist was not completed, PCP orders and nursing flow sheet not completed. IDT met on 4/24/2107 and agreed that Direct Care professionals and nursing needed to be retrained on [Individual #41]'s CIP and completing the proper documentation according to restraint policy."
- For Individual #173's mechanical restraint on 1/4/17, the Center indicated that the Restraint Checklist and the Face-To-Face Debriefing form were "unavailable." There were no IPNs provided addressing this mechanical restraint, and it appeared that the PCP's order for arm splints was entered into IRIS at 1:45 p.m., and not at 10:34 a.m.
- For Individual #134, the Center indicated: "[Individual #134] 2/1/2017 medical restraint {gloves} checklist was not completed. Section C Lead… sent an email to BHS and psych assistant for staff [direct care professional and nursing to be retrained on completing medical mechanical restraint checklist per policy]. On 2/3/2017 Psych assistant sent a prefilled in-service to BHS. On 2/6/2017 Section C lead… sent a prompt via email inquiring what the status was on in-service completion and CC Director of Behavior Services. Section C lead… did not receive a response." PCP orders were provided. The IPNs provided did not include complete documentation addressing the use of gloves, the effectiveness of the gloves, the condition of the SIB wounds, the individual's mental status, or ability to function with the gloves, condition of her hands, her tolerance of the gloves, and any assistance needed because of the gloves, such as eating, bathroom, hygiene. etc. In addition, the flow sheets provided had information cut off of the forms.

Nursing staff documented and monitored mental status for Individual #202 on 2/22/17 at 9:45 a.m.

b. and c. As noted above, for some restraint episodes reviewed, the Center did not have needed documentation. In addition, for Individual #109, an LVN's IPN, dated 1/15/17 at 8:36 p.m., indicated that the individual stated: "My pain has gone," and noted Tylenol was effective. However, there was no indication why the Tylenol was given, or when it was given. It was unclear if the "pain" was a result of the restraint episode earlier that day.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Low performance was primarily a function of improperly managed and/or documented implementation of crisis intervention mechanical restraint, PMR-SIB, and/or medical restraint. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	109	459	173	202	134	41				
15	Restraint was documented in compliance with Appendix A.	43% 3/7	1/1	0/1	1/2	1/1	0/1	0/1				
Comments: 15. For Individual #459 4/13/17, location information was not on the documentation. For the other three that did not meet criteria, documentation was not provided or available.												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	109	459	173	202	134	41				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	75% 3/4	1/1	1/1	0/1	1/1	N/A	N/A				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments: 16. No information was provided for Individual #173 1/4/17.												

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)												
Summary: There were no occurrences of crisis intervention chemical restraint. This indicator will remain in active monitoring for review at the next onsite visit, if there are any occurrences at that time.			Individuals:									
#	Indicator	Overall Score										
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	N/A										
48	Multiple medications were not used during chemical restraint.	N/A										
49	Psychiatry follow-up occurred following chemical restraint.	N/A										
Comments: 47-49. There were no occurrences of crisis intervention chemical restraint.												

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Performance maintained at a high level, with only one investigation not meeting the various criteria required for this indicator. This important indicator will remain in active monitoring. Also, protocols for individuals designated for potential streamlined investigations need to be followed.			Individuals:								
#	Indicator	Overall Score	333	109	459	173	202	313	134	127	630
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	91% 10/11	1/1	1/1	1/1	1/1	2/2	0/1	2/2	1/1	1/1

Comments:

The Monitoring Team reviewed 11 investigations that occurred for nine individuals. Of these 11 investigations, 10 were DFPS investigations of abuse-neglect allegations (three confirmed, three unconfirmed, two inconclusive, one unfounded and streamlined, one administrative referral back to the facility). The other one was for facility investigations of an unauthorized departure. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #333, UIR 17-122, DFPS 45089685, confirmed physical abuse allegation, 1/11/17
- Individual #109, UIR 17-163, DFPS 45171187, unconfirmed physical abuse, 2/26/17
- Individual #459, UIR 17-223, DFPS 45253486, unfounded physical abuse allegation, streamlined, 4/25/17
- Individual #173, UIR 17-134, DFPS 45122040, confirmed neglect allegation, 1/21/17
- Individual #202, UIR 17-209, DFPS 45233394, confirmed physical abuse allegation, 4/9/17
- Individual #202, UIR 17-224, DFPS 45262269, inconclusive neglect allegation related to a sexual incident, 5/1/17
- Individual #313, UIR 17-192, DFPS 45211561, inconclusive physical abuse allegation related to a discovered fracture, laryngeal/throat, 3/27/17
- Individual #134, UIR 17-216, DFPS 45239624, administrative referral, neglect allegation, 3/17/17
- Individual #134, UIR 17-200, DFPS 45220378, unconfirmed neglect allegation related to a witnessed fracture, right knee, 4/1/17
- Individual #127, UIR 17-219, unauthorized departure, date unknown
- Individual #630, UIR 17-128, DFPS 45113815, unconfirmed neglect allegation, 1/19/17

1. For all investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring

Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all 11 investigations, the staff-related antecedent actions occurred, and trends were reviewed (though for nine of the 11, there were no trends because the investigation was solely about allegations of staff actions). For Individual #127 17-219, the unauthorized departure behavior was already being addressed in his PBSP and the PBSP was being implemented. Overall, 10 of the investigations met all of the criteria. The exception was Individual #313 17-192. This investigation concluded the injury was a result of his problem behaviors. Though these were addressed in his PBSP and somewhat in his PNMP, these plans were not being implemented regularly or correctly.

Nine individuals at Denton SSLC were designated by DFPS for streamlined investigations due to their making frequent calls that proved to be unfounded and that met DFPS's various criteria for inclusion on this list. In addition to DFPS protocols, DADS recently implemented a protocol/policy for supporting individuals who fell into this category. One of the individuals in the review group had this designation (Individual #459). The facility was not following the DADS protocol/policy.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.

Summary: Performance did not improve, though the Monitoring Team had expected to see improvement given the attention and focus described at the time of the last review. Details are described below. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	173	202	313	134	127	630
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	73% 8/11	1/1	1/1	1/1	1/1	2/2	1/1	0/2	1/1	0/1

Comments:

2. The Monitoring Team rated eight of the investigations as being reported correctly. The other three were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator.

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #134 17-216: During discussions while onsite, the facility management said that this was reported anonymously. Nevertheless, SSLC staff (e.g., nursing, maybe others) were aware of this issue well before it was actually reported. Given that staff were aware of this issue, it should have been viewed as something that should have been reported to DFPS (or there should have been documentation of discussion with the IMC and/or IMRT to determine if it was reportable). In response to the draft of this report, the State wrote that the DFPS office, facility director, and chief nursing executive discussed and then agreed that the circumstances of the allegation involved clinical practice that fell under state guidelines regarding referral back to the

facility for investigation rather than investigation by DFPS.

- Individual #134 17-200: Per the DFPS report, the incident occurred on 4/1/7 at 7:52 am and was reported to them at 5:25 pm. Per the UIR, the facility director/designee was notified of a possible serious injury at 1:07 pm and was again notified at 4:53 pm. There is nothing in the UIR that described any review activity leading to a decision to report to DFPS. The usual who-reported entry on the UIR was not present.
- Individual #630 17-128: The UIR stated that the reporter was unknown. The incident allegedly occurred at 7:30 pm and was received at DFPS intake at 8:57 pm (more than one hour). The UIR did not describe any possible reporting scenario to explain this.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.

Summary: These basic protections were not sufficiently in place at Denton SSLC. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	173	202	313	134	127	630
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	0% 0/1	Not rated	Not rated	Not rated	Not rated	Not rated	0/1	Not rated	Not rated	Not rated
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

3. Because indicator #1 was met for eight of the individuals, this indicator was not scored for them. The indicator was scored for the other individual and criteria were not met, that is, three staff members who worked with this individual were unable to correctly answer all of the Monitoring Team's relevant questions.

4. The required posters with reporting information were missing from the homes of seven of the nine individuals. For two individuals, staff were unable to describe ways that the individual shows he or she is upset or concerned about something.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.

Summary: During review of investigation documentation for this domain, the Monitoring Team noticed that many investigations did not document the re-assignment of alleged perpetrators in about half of the investigations. Therefore, due to this poor performance, this indicator will be returned to active monitoring.			Individuals:								
#	Indicator	Overall									

		Score									
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. However, due to poor performance, this indicator will be moved back into active monitoring.									
Comments:											

Outcome 5– Staff cooperate with investigations.											
Summary: In this review and in the previous three reviews, one or more investigations found a problem with staff cooperation with the investigation. Therefore, this indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	173	202	313	134	127	630
7	Facility staff cooperated with the investigation.	91% 10/11	1/1	1/1	1/1	1/1	1/2	1/1	2/2	1/1	1/1
Comments: 7. For Individual #202 17-209, the DFPS report (on page 3) noted that two staff did not show up for scheduled interviews. There wasn't anything in the UIR that acknowledged this or described any follow-up action by the facility to facilitate staff cooperation or if there was any administrative action taken.											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: With sustained high performance, indicator 9 might be moved to the category of requiring less oversight after the next review. Facility incident management department staff involvement in reviewing findings as per the requirements of indicator 10 might result in higher performance on that indicator. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	173	202	313	134	127	630
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 11/11	1/1	1/1	1/1	1/1	2/2	1/1	2/2	1/1	1/1
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e.,	82% 9/11	1/1	1/1	1/1	1/1	2/2	1/1	0/2	1/1	1/1

	evidence that was contraindicated by other evidence was explained)										

Comments:
10. Most UIRs were written in a way that made it hard to follow the story of the incident. There was a lot of disjointed information, and they did not read like an investigation. We recommend that Denton SSLC gets some technical assistance on this, or perhaps models from some of the other Centers.

Both investigations for Individual #134 did not meet criteria for this indicator. For 17-216, facility investigation concluded that there were multiple systems issues that contributed to this problem and that needed to be addressed. Based on the information, there may have been issues with individual staff performance that were not identified and/or addressed in the investigation. For 17-200, various performance issues were identified for which a confirmation was a logical determination. The injury could have been avoided or mitigated if there had been proper use of her gait belt and if the facility ensured that only trained staff worked with her. This is a systems issue related to training. The facility's self-review didn't question this or discuss it in its review process.

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Performance on both indicators declined compared with the last review. These indicators are about important quality aspects of investigations and both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	173	202	313	134	127	630
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	55% 6/11	1/1	1/1	1/1	0/1	1/2	0/1	1/2	1/1	0/1
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	30% 3/10	0/1	0/1	0/1	0/1	1/1	0/1	0/2	1/1	1/1

Comments:
12. Three investigations were completed more than 10 days with no extension requests. Two others had extension requests, but they did not detail extraordinary circumstances.

13. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. Here, these were related to late reporting, alleged perpetrator re-assignment, absence of adequate extension requests, and/or reconciliation of possible staff actions related to the allegation and/or injury. Thus, a score of zero regarding these aspects in the indicators earlier in this section of the report does not result in an automatic zero score for this indicator. Identifying,

correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.											
Summary:			Individuals:								
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.										
Comments:											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary:			Individuals:								
#	Indicator	Overall Score									
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.										
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.										
Comments: 17. There were three investigations at Denton SSLC that included confirmations of physical abuse category 2. In two of the cases, the employees' employment was not maintained. In the third, there were no identified employees, but a systems issue was identified and, as a result, specific staff training was conducted. 18. The facility continued its excellent process for tracking recommendations to completion and collecting the evidence to validate completion. It included a final review by the facility's assistant independent ombudsman.											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. Denton SSLC continued to regularly collect and review relevant incident- and allegation-related data. This was good to see and sets the occasion for ongoing quality improvement. Given the many performance improvements needed in incident management (as evidenced in the above outcomes and indicators), likely some corrective actions should have been identified. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score										
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes										
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No										
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	N/A										
23	Action plans were appropriately developed, implemented, and tracked to completion.	N/A										
Comments: 19-20. Criteria for these indicators were met. 21-23. The Monitoring Team reviewed QAQI Council documentation/minutes and observed the QAQI Council in its monthly meeting during the onsite review week. Content of documentation and the meeting included the quarterly review of incident management data. Necessary data were presented and discussed. Appropriate conclusions and recommendations occurred. No CAPs were presented, but given some of the low scores in the above set of outcomes and indicators in this section of the report, some were likely needed.												

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	If individual is administered total intravenous anesthesia	0%	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

	(TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0/2									
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA needed to be expanded and improved. Since the last review, Center staff worked on making these updates, which was good to see. One piece that was missing from the criteria for the use of TIVA policy was that for individuals that met the criterion of three failed attempts previously who have another dental need, then only need one failed attempt before proceeding with the use of general anesthesia.

With regard to the medical clearance for TIVA, the Center had not yet developed the needed policy.

For these two instances of the use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and post-operative vital sign flow sheets were submitted.

b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess this indicator.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	N/A	0/2	N/A	N/A	N/A	N/A

Comments: a. For Individual #269's two episodes of pre-treatment sedation for the completion of a mammogram, evidence was not found of input of the interdisciplinary committee/group on the use of medication and dosage.

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: IDTs were discussing the need for pretreatment sedation for dental procedures, including some discussion of desensitization strategies with help from the specialty behavior analysis clinic on campus. However, none of these were implemented and no follow-up was evidenced. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	459	240	173	313				
1	IDT identifies the need for PTS and supports needed for the	100%	1/1	1/1	1/1	1/1	1/1				

	procedure, treatment, or assessment to be performed and discusses the five topics.	5/5									
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A	N/A	N/A	N/A	N/A	N/A				
4	Action plans were implemented.	N/A	N/A	N/A	N/A	N/A	N/A				
5	If implemented, progress was monitored.	N/A	N/A	N/A	N/A	N/A	N/A				
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A	N/A	N/A				

Comments:
1-6. Five of the individuals, Individual #333, Individual #459, Individual #240, Individual #173, and Individual #313, had experienced pretreatment sedation over the previous 12 months. All had received a fair to poor oral hygiene rating. The Monitoring Team requested desensitization plans for each of these five individuals as it was noted in their ISPs that they would be referred to the Behavior Analysis Resource Center.

For all five, information was provided noting that he/she "does not have a restraint plan with unit level strategies, nor is (he/she) receiving in clinic desensitization services." The QIDP monthly reviews for Individual #240 indicated that a request had been sent to the BARC on 10/26/16 and that it was "completed/done" by 4/17/17. This does not correspond to the information, referenced above, that was provided onsite. For all five, it was unclear if desensitization services were not being provided because a referral had not been sent or because BARC had determined the individual was not a candidate. Although each had a toothbrushing SAP that was being implemented, indicator 2 is rated with a zero score because there was no evidence that desensitization plans had been considered/implemented as recommended by their teams.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	345	99	203	398					
a.	For an individual who has died, the clinical death review is completed	100%	1/1	1/1	1/1	1/1					

	within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	4/4									
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

Comments: a. Since the last review, 13 individuals died. The Monitoring Team reviewed four deaths. Causes of death were listed as:

- On 10/2/16, Individual #696 died at the age of 64 of hepatic cirrhosis;
- On 10/18/16, Individual #398 died at the age of 60 of Down Syndrome/dementia, cardiovascular disease, and aspiration syndrome and dysphagia with gastrostomy/jejunostomy (G/J) tube;
- On 11/6/16, Individual #203 died at the age of 74 of cardiac arrest, aspiration pneumonia, incarcerated inguinal hernia, and atrial fibrillation;
- On 11/30/16, Individual #132 died at the age of 66 of cardiopulmonary arrest, sepsis, and aspiration pneumonia;
- On 12/3/16, Individual #222 died at the age of 55 of presumed cardiac arrhythmia, and cardiac hypertrophy;
- On 1/16/17, Individual #551 died at the age of 52 of end stage chronic obstructive pulmonary disease with chronic respiratory failure;
- On 1/25/17, Individual #236 died at the age of 64 of pneumonia;
- On 2/6/17, Individual #200 died at the age of 35 of complications of renal failure, and gastrointestinal (GI) bleed;
- On 2/10/17, Individual #517 died at the age of 51 of pneumonitis due to inhalation of food or vomit;
- On 2/12/17, Individual #99 died at the age of 44 of fatal arrhythmia, acute respiratory failure, chronic respiratory failure, and chronic restrictive lung disease;
- On 3/12/17, Individual #345 died at the age of 61 of acute respiratory failure, pneumonia, sepsis, and cholecystitis;
- On 3/18/17, Individual #463 died at the age of 57 of pneumonia; and
- On 5/3/17, Individual #433 died at the age of 49 of tracheal hemorrhage.

b. through d. Evidence was not submitted to show the Facility conducted thorough reviews of nursing care, or an analysis of medical/nursing reviews to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. Some examples include:

- For Individual #99:
  - The Center provided a half-page document entitled "Quality Improvement Death Review of Nursing Services." It merely indicated that Individual #99 had a Do Not Resuscitate Order (DNR), and was not on hospice, and that no issues were found from review of the record, all risk ratings were appropriate according to the individual's health status and medical history, and that there were plans in the IHCP for the individual's high and medium risk areas. The nursing review generated no recommendations. However, based on additional information the Center provided, on 2/12/17, staff came into Individual #99's room to reposition his roommate and heard a beeping noise. The staff member saw Individual #99's ventilator tubing lying on his chest. He was very pale, his lips were pale, and he was cold to the touch. He took what looked like one breath, and had a weak thread carotid pulse. An RN activated the emergency response system and Respiratory Therapy responded and began to bag him. Emergency Medical Services (EMS) arrived and pronounced Individual #99 dead at 4:55 p.m. An emerging issue was noted regarding nursing staff's ability to hear an alarm go off in the Nursing Station. The RN involved in this incident noted she did not hear the alarm from where she was sitting in the Nursing Station, and when she entered the room, she heard the peripheral capillary oxygen saturation (SPO2) monitor, but the ventilator alarm was not making any noise. It was of significant concern that the nursing death review did not mention this issue or how it might have contributed to the individual's death. Overall, the review was superficial and did not reflect a comprehensive review of the quality of nursing care and services. Given that Denton SSLC is designated to serve individuals with some of the most intensive medical needs, it is essential that thorough and complete reviews of nursing care are conducted for all mortalities. The documentation indicated that "DADS Regulatory re-opened this death investigation from our annual Survey and the facility was placed on an IJ [immediate jeopardy] for Client Rights and Healthcare Services. The facility submitted a letter of credible allegation and the plan was accepted and IJ was lifted. The Facility will receive a 90-Day Termination in the areas of Client Rights and Healthcare Services."
  - Moreover, the mortality reviews did not generate a recommendation for the Respiratory Therapists to provide training to the residential staff on how to use the new anti-disconnect equipment bought for each individual using a ventilator, including how to use it in bed, in a chair, etc.; and what to look for to ensure it is providing the appropriate connection.
- For Individual #398:
  - The mortality reviews did not address the following concern included in the physician's death review: "She was found… face down lying on her stomach with her face and head in the right hand corner of the bed… The [individual's] face seemed to be wedged in the right corner. Her normal position is to be alternated every 2 hours in the semi sidelying position with her back supported. It would be difficult for her to roll forward in that position if she is placed with the proper support… She has never been observed to roll over before and she has limited strength in her upper extremities. She can move her legs. The cause of death is possible hypoxia due to aspiration and emesis due to the posture that she was in. It is uncertain how she got in that position."
  - As noted above with regard to Individual #99, the Quality Improvement Death Review of Nursing Services offered a superficial review of Individual #398's nursing services. The only conclusion generated was that the IDT did not assign all risk ratings appropriately. More specifically, the IDT rated her choking risk as medium the previous year, but changed it to low in the current IRRF. The nursing review indicated: "She hadn't had any choking incidents in the last year but that was possibly due to the number of supports in place. It may have been more appropriate to have left the risk rating at the medium level." A recommendation was generated from the Administrative Death Review addressing

this issue, specifically that the QIDP Coordinator and RN Case Manager Supervisor would do training with the QIDPs and nurses on risk ratings.

- For Individual #203:
  - The mortality reviews did not include a recommendation(s) to address medication errors that the Clinical Death Review indicated the RN Case Manager noted concerning Coumadin: "there have been days that he has not been given the correct dose. This explains the decrease in INR [international normalized ratio]."
  - Similar to the nursing reviews for other individuals, the Quality Improvement Death Review of Nursing Services offered a superficial review of Individual #203's nursing services. For example, the issue discussed above regarding the individual's Coumadin was not a finding of or even mentioned in the nursing services review.
- For Individual #345, the Quality Improvement Death Review of Nursing Services offered only the following recommendation: Determine whether changes/updates need to be made to the IHCP due to the increased risk ratings from 2/22/17 Changes of status meeting (since no additional action steps were added to the existing IHCP). If the nurse completing the Quality Improvement Death Review of Nursing Services had conducted a thorough review, she/he would have been able to make this determination and generated an appropriate recommendation.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, as noted above, for Individual #398, a recommendation was generated from the Administrative Death Review that the QIDP Coordinator and RN Case Manager Supervisor would do training with the QIDPs and nurses on risk ratings. Although the Center provided a large packet of material addressing ISPs, it appeared that this was a "read and sign" training rather than classroom and/or competency-based training. In addition, there was no further monitoring put in place to ensure that IDTs appropriately rated risks, so the Center was not able to provide assurances that concerning practices at the Center changed.

Evidence was not available to show that the Center implemented the following recommendation related to Individual #99's mortality review: provide adaptation so that all individuals can more easily go places that require extra respiratory support.

Domain #2: Using its policies, training, and quality assurance systems to establish and maintain compliance, the State will provide individuals in the Target Population with service plans that are developed through an integrated individual support planning process that address the individual's strengths, preferences, choice of services, goals, and needs for protections, services, and supports.

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 12 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, two additional indicators will move to the category of less oversight in the area of ISP development.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Assessments

The IDTs did not consider what assessments the individual needed and would be relevant to the development of an individualized ISP. IDTs did not, for the most part, arrange for, and obtain, needed, relevant assessments prior to the IDT meeting.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. As a result, for the great majority of the risk ratings reviewed, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

Three of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals' needs. Moving forward, the Medical Department should focus on ensuring medical assessments include as applicable, family history, childhood illnesses, lists of medications with dosages at the time of the AMA, and plans of care for each active medical problem, when appropriate.

During this review, improvement was noted with regard to the timely completion of annual dental exams and annual dental summaries. While maintaining this progress, the Center should continue its focus on improving the quality of dental exams and summaries.

Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the

chronic conditions and promote amelioration of the at-risk condition to the extent possible. In addition, often, when individuals experienced changes of status, nurses did not complete assessments consistent with current standards of practice.

It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. IDTs need to improve the timely referral of individuals to the PNMT, and/or the PNMT needs to make self-referrals. The Center also should focus on completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, particularly Behavioral Health Services staff, and the quality of the PNMT reviews and comprehensive assessments.

Good improvement was demonstrated in comprehensive psychiatric evaluation (CPE) format and content. Some improvements remained necessary in ensuring consistent diagnoses across documents and disciplines.

Behavioral assessments continued to be incomplete or not current or updated. Not all functional assessments were current or updated. On the other hand, functional assessments contained the required content.

The Center should focus on improving the timeliness of OT/PT consults when individuals experience changes in status. The quality of OT/PT assessments needs improvement.

Improvements were seen in SAPs being based upon assessments and being practical, functional, and meaningful. Reliable and valid data, however, were not collected or assessed.

Individualized Support Plans

The development of individualized, meaningful personal goals in six different areas was not yet at criteria, but some small progress was evident. The most encouraging was that one individual had goals that met criteria in five of the six areas. This indicates that Denton SSLC has the capacity and ability to create goals in all areas, except, at this point, in the IHCP/health/wellness area (as is the case with most of the SSLCs).

ISPs were revised annually. ISPs, however, were not implemented in a timely manner, and some aspects were not implemented at all. Part of the problem with implementation was that most ISP action plans were service objectives. Some were even less formal than that, such as merely statements that activities would occur, with no service objective implementation plans. Some of these action plans should have instead been conceptualized as skill acquisition plans, with a formal implementation plan, staff instructions, data collection methodology, and so forth.

The QIDPs at Denton SSLC were unable to complete the monthly reviews and, as a result, progress was not assessed, and resultant actions not planned or taken.

Although some progress was seen, there were not yet psychiatry-related goals that identified psychiatric indicators linked to the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status.

Psychiatric providers attended most ISP meetings. During an ISP observed during the monitoring visit, the psychiatrist attended and led the discussion regarding the individual's behavioral health. Also, based on the documents reviewed, it was apparent that the psychiatrists were increasingly involved in leading this discussion during the ISP meetings.

Individuals had PBSPs and goals that were, for the most part, measurable and based upon assessments. Assessments of inter-observer agreement and data timeliness were not occurring as they needed to be. There was improvement in PBSP implementation timeliness.

It was positive that IDTs of individuals reviewed updated PNMPs/Positioning Schedules at least annually, or as the individual's needs dictate.

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs, as well as nursing and physical and nutritional support interventions.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but some small progress was evident. The most encouraging was that one individual had goals that met criteria in five of the six areas. This indicates that Denton SSLC has the capacity and ability to create goals in all areas, except, at this point, in the IHCP/health/wellness area (as is the case with most of the SSLCs). On the other hand, for the other five individuals, two had personal goals that met criteria in one area, and three had personal goals that met criteria in zero areas. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	173	313	134	269	255			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	5/6	1/6	0/6	0/6	0/6	1/6			
2	The personal goals are measurable.	0%	1/6	0/6	0/6	0/6	0/6	1/6			

		0/6									
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #109, Individual #173, Individual #313, Individual #134, Individual #269, Individual #255). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Denton SSLC campus. Overall, the Monitoring Team failed to identify areas of significant progress during this visit regarding the development, implementation, monitoring, and revision of the ISP.

The ISP relies on the development of personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology. None of the six individuals reviewed had individualized goals in all areas. Therefore, none had a comprehensive set of goals that met criterion.

1. During the last monitoring visit, the Monitoring Team found there had been little discernible improvement overall in the individualization and measurability of personal goals from earlier findings. At that time, outcomes for the six reviewed ISPs remained very broadly stated and general in nature and/or were very limited in scope. Overall, four personal goals met criterion at that time. During the current onsite visit, seven personal goals met criterion, reflecting a small measure of progress. Findings included:

- Five of the personal goals that met criterion were for Individual #109. Conceptually, these goals promoted success and accomplishment, being part of and valued by the community, and choosing where and with whom to live. They also provided an expectation that he would learn new skills and have opportunities to try new things, and reflected an IDT focus on his preferences.
    - This was very positive.
    - The only personal goal area that did not meet criterion for Individual #109 was for health and safety. The Monitoring Team reviewed his Integrated Health Care Plan (IHCP) for evidence of personal goals, but did not find it included personal goals with clinically relevant and measurable objectives that delineated specifically what the IDT expected could be accomplished. For example, Individual #109 has had repeated falls over the past two years and the IHCP goal in that area was for him to remain free of injury. This was overly broad and did not reflect an individualized approach to the nature of his frequent falls or preventing them.
    - The Monitoring Team is aware that state office is preparing to provide training and support to centers to help them to create personal goals with clinically relevant and meaningful objectives in the area of health/wellness/IHCPs.
- Other personal goals that met criterion were the living options goal for Individual #173 and the independence goal for Individual #255.
- Some other goals appeared on initial review to hold promise, in that they seemed to reflect aspiration, a level of community

participation, and integration and creativity on the part of the IDT. Upon deeper review and staff interview, however, these goals had little to do with personal preferences or aptitudes and the IDT had not attempted to assess whether the individual might show an interest. The ISP preparation meeting is intended to identify such issues and give the IDT time to evaluate the feasibility of their proposed goals and action plans before finalizing them at the ISP annual meeting. This would be particularly important when the IDT has proposed a tentative goal that may have benefit for an individual, but lacks any clear evidence of being related to his or her preferences. If done methodically to obtain valid data, this could also satisfy the requirement that personal goals reflect input from the individual on what is important to him or her. For example:

- At the time of his ISP preparation meeting, the IDT identified joining a book club/read along program as the leisure goal for Individual #313, but no evidence indicated his interest in this activity. The IDT had not made an effort to evaluate his interest or willingness to participate prior to the ISP annual meeting, even though the IDT knew potential barriers existed.
- All Individual #255's assessments indicated she didn't want to work, but the IDT developed a goal for her to work as a secretary. The IDT did not complete a pre-ISP assessment to evaluate whether this might be interesting to her or otherwise feasible.

2. Of the seven personal goals that met criterion for indicator 1, two met criterion for measurability. The Monitoring Team reviewed the personal goals and their underlying action plans in making this determination. The action plans did not provide a clear path toward achieving goals that could be measured.

- The best example of IDT development of a set of action plans that would support attainment of a goal was for Individual #255's goal to make nachos, but even these did not contain baseline measures, specific learning objectives, and measurement methodologies.
- Individual #109's independence and work goal, to work at a specific pizza restaurant, did not lay out a clear path for achievement. This was reflected at his annual ISP meeting observed by the Monitoring Team while onsite, at which time his mother/LAR expressed confusion and frustration that she couldn't understand how that goal could ever happen.
- For Individual #173, it was positive that the IDT made an effort to consider how leisure, vocational, and behavioral action plans might support the achievement of the living options goal to return home to live with his parents. This was a move in the right direction. To meet criterion for measurability, though, the IDT first needed to document in a quantifiable manner what the parents would require to make living in their home feasible and then build the action plans around those clear parameters.

3. For the seven personal goals that met criterion in indicator 1, none had reliable and valid data, due in part to lack of implementation.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.	
Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators refer to the full set of action plans. That is, the qualities that are being monitored by these indicators may be evident in different action plans within the set of goals and action plans for the individual. Of these 11	Individuals:

indicators, four showed improvement (albeit slight) since the last review. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	109	173	313	134	269	255			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	1/1	0/1	0/1	0/1	0/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
Comments: As Denton SSLC further develops more individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators. 8. Most individuals did not have personal goals that met criterion, as described under indicator 1 above. For those who did, ISP goals generally did not have a clear set of action plans that would serve as a road map for their ultimate achievement, as described under											

indicator 2 above.

9. One of six ISPs (for Individual #109) contained a set of action plans that clearly integrated preferences and opportunities for choice. For the other individuals, the action plans minimally integrated opportunities for day to day choice making. For example, for Individual #269, the IDT did not focus attention on enhancing her ability to communicate and make choices, even though she had the ability to use sign language. The only action plan for using her sign language was to use the sign for "calm" to indicate why she took a medication.

10. None of these six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making.

11. Two of six ISPs (for Individual #109 and Individual #255) met criterion for this Indicator. For example, for Individual #255, action plans included continued physical therapy for mobility and learning to prepare her own food, including using a picture recipe and shopping for ingredients. Otherwise, action plans did not assertively promote enhanced independence for the other individuals. For example, communication forms an important foundation for exercising independence, but the respective IDTs did not assertively address communication needs for Individual #173, Individual #313, and Individual #269.

12. The IDTs did not assertively address risk areas, particularly around falls and weight, and the PNMT did not take an active role in helping the IDTs complete corresponding root cause analyses that should have been the basis for intervention and/or prevention. IDTs were unsure of the criteria for PNMT involvement and proactive clinical judgment was not being exercised when determining the need for formal PNMT assessment and engagement.

- The Center needs to consider whether a formal CAP is needed in this area.
- Individual #269 had at least 20 falls between 12/27/16 and 6/21/17 (data were unreliable, so there may have been additional falls), and had sustained two serious injuries. Thus far in June 2017, she had five documented falls, so the trend was not decreasing. The IDT had twice discussed her falls during that time frame, but no formal falls assessment or root cause analysis had been completed and she was not on the PNMT caseload.
- For Individual #134, per the Monitoring Team's discussions, the PNMT needed to conduct a formal comprehensive assessment to address infections, aspiration, pica, and opportunities for least restrictive feeding, among other risk areas. Other concerns included the lack of a comprehensive falls assessment despite repeated falls and fractures.
- Individual #313 recently had an MBSS indicating he should be not eat or drink orally (NPO). His IDT met and acknowledged this finding as well as the fact that he was aspirating on all textures, but disagreed with the NPO recommendation based upon his preferences and possible increases in behaviors that might result. The IDT did not put a comprehensive plan in place for increased monitoring or additional staff training given this heightened risk.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated, also as described throughout this report. In addition to the examples provided in indicators 11 and 12 above, other examples included:

- Many of Individual #109's needs had a sensory component related to his autism diagnosis, but the IDT developed no action plans to address these. In addition, his Positive Behavior Support Plan (PBSP) was from 2014 and included a response-cost strategy that needed to be reviewed by the Human Rights Committee.
- For Individual #173, the IDT had not obtained an assessment for use of a Picture Exchange Communication System (PECS) or

provided him with PECS, despite a history of using these successfully in past.

- Individual #313's communication assessment did not meet criterion and did not address teaching him more functional ways to indicate he didn't like something besides grimacing and groaning, or how to request items since he had an understanding of the use of items.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these individuals, with few specific, measurable action plans for community participation that promoted any meaningful integration. The exception was for Individual #109, whose ISP included community work and integrated community leisure action plans. Examples of those that did not meet criterion included:

- Individual #255 had limited opportunities for community participation and no methodology for integration. Based on her stated interests, the IDT should have considered an action plan, if not a goal, for joining a church group. Her Functional Skills Assessment (FSA) indicated an action plan for this was needed, but the IDT did not address it.
- Individual #269 had some limited opportunities for community participation, but these included no methodology for integration.
- Due to the nature of Individual #173's behaviors, most community participation was contingent upon implementation of his behavior plan, but it was not implemented until June 2017.

15. One of six ISPs (for Individual #173) considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Examples of those that did not meet criterion included:

- Individual #313 had a broad and generalized goal for day program. Action plans included a skill acquisition plan (SAP) to retrieve magazines from the closet and one very broad action plan to offer exploration of three new activities within next year. His goal for joining a book club and action plans for attending monthly book readings could have possibly formed the basis for integrated day programming, but these action plans did not call for regular and ongoing participation.
- Individual #269 had a goal for community employment, but no action plans that would lead to achievement. The only action plan was for her to remain focused on her task for 20 minutes while working at the Center.

16. One of six ISPs, for Individual #109, had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. The IDTs did not place significant focus on skill acquisition. For example:

- Some of the action plans created as service objectives or statements of activities should have been conceptualized as skill acquisition plans instead, with a formal implementation plan, staff instructions, and data collection methodology. For example, Individual #255 had a personal goal to make nachos. Action steps were only formulated as service objectives, but actually represented skills to be obtained. These included using a picture recipe for making nachos, going shopping for the ingredients, making nachos for her apartment once per month, and marking off the calendar dates leading to preparing nachos. No implementation plans had been developed and none of the steps had yet been implemented.
- Individual #255's ISP also did not include substantial opportunity for community integration or other things that were important to her, such as joining a church group and swimming.
- Individual #134's day, overall, was extremely limited in terms of meaningful active engagement.
- Individual #173's ISP included limited daily opportunities for skill acquisition. His only active day program action plan was to

retrieve magazines from the closet. This SAP was intended as an opportunity to make choices, but it did not include any methodology for supporting choice making. The service objective for exploring three new activities in the year had no implementation plan and there was no evidence it was being implemented.

17. The IDT did not consistently address barriers to achieving goals. For example, IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described in indicator 26. Individual #109's 2017 ISP, as observed onsite by the Monitoring Team, provided another example, in that several personal goals were continued from the previous year without addressing the barriers that prevented their implementation.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often missing key elements and data had not been demonstrated to be valid or reliable, as described elsewhere in this report. Living options action plans often had no measurable outcomes related to awareness.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: Criterion was met for some indicators for some individuals, but overall, performance was about the same as last time, with some indicators scoring slightly higher and some scoring slightly lower. More focus was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are conducting thorough discussions of living options and putting plans into place to address obstacles to referral. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	109	173	313	134	269	255			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community	50%	1/1	1/1	0/1	0/1	0/1	1/1			

	placement (or the individual was referred for transition to the community).	3/6									
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Two of six ISPs included a description of the individual's preference for where to live and how that preference was determined. For Individual #173, the IDT accurately indicated that his parents wanted him to return home and identified this as his preference. For Individual #313, the IDT based their determination of a small, quiet group home based on his known preferences for small and quiet environments. Examples of descriptions that did not meet criterion included:

- For Individual #255, the ISP indicated she wanted to live in a group home and that was based on her statement, but later documented she said she wanted to live at Denton SSLC. Other documents, such as the PSI, also indicated that she wanted to live in a group home near her family. The IDT did not resolve these conflicting statements.
- For Individual #269, the ISP contained a very general statement that did not articulate a coherent basis for determining her preference. It stated the IDT looked at her preferences to determine where she would more likely be able to get the things she prefers and that was determined to be in the community, and this was why the goal was set to live close to her mother.

20. The Monitoring Team observed Individual #109's annual ISP meeting. The IDT provided a description of where he wanted to live based on his stated preferences for his desire to live in a group home, but did not really acknowledge and discuss the potential for him to live with his mother again at some point. This was his expressed long term objective and his mother stated she hoped that might be possible someday.

21. Overall, none of six ISPs fully included the opinions and recommendation of the IDT's staff members.

- Current assessments by key staff members were sometimes not available at the time of the ISP. Those that were present generally provided a statement of the opinion and recommendation of the respective team member.
    - This was an indicator of progress, but it was not yet consistent across all disciplines.
- ISPs did not consistently include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's need. For some ISPs, the IRIS format listed a series of identical statements

stating a professional recommendation, but they were not attributed to any specific discipline. The Monitoring Team could not determine whether all disciplines had contributed or what specific recommendations they made. For example:

- One of the sub-indicators the Monitoring Team reviews is whether the ISP included independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's needs. This is in addition to consideration of the presence of statements and recommendations found in the assessments and is meant to demonstrate a thorough discussion is being held at the ISP meeting. The ISPs did not make this clear. For example, for Individual #109, the Monitoring Team could not determine whether the independent recommendations referenced were being taken from the assessments rather than a discussion at the IDT meeting. The ISP noted no recommendation was found in the speech assessment, for example, and some other members who were referenced did not actually attend the meeting.
- For Individual #255, the listing of statements and recommendations only specified nursing, psychiatry, nutrition, and vocational.
- For Individual #313, the ISP did not show a PCP recommendation.

22. The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, for all six individuals.

23. None of six individuals had a thorough examination of living options based upon their preferences, needs, and strengths. The ISPs did not reflect a robust discussion of available settings that might meet individuals' needs.

24. Three of six ISPs, for Individual #109, Individual #173, and Individual #255, identified a thorough and comprehensive list of obstacles to referral in a manner that should allow for the development of relevant and measurable goals to address the obstacle. For the other three individuals, the IDTs did not include individual awareness as a formal barrier, even though the narrative made clear this was a need in each case.

25. The Monitoring Team observed Individual #109's ISP annual meeting while onsite. The IDT identified behavioral/psychiatric needs and individual awareness as barriers.

26. None of six individuals had individualized, measurable action plans to address obstacles to referral. The action plans to address individual awareness and LAR reluctance did not have individualized measurable action plans with learning objectives or outcomes. Individual #109 and Individual #255 both had behavioral/psychiatric obstacles listed. The IDTs did not quantify what behavioral/psychiatric thresholds would need to be met for community transition to be considered, which was needed to develop a specific action plan.

27. The Monitoring Team observed Individual #109's annual ISP meeting. The IDT did not articulate a clear set of plans to address/overcome the barriers.

28. None of six ISPs had individualized and measurable plans for education.

29. All six individuals had obstacles identified at the time of the ISP.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.

Summary: ISPs were revised annually. This has been the case for some time at Denton SSLC, therefore, indicators 30 and 31 will be moved to the category of requiring less oversight. ISPs, however, were not implemented in a timely manner, and some aspects were not implemented at all. This and the other indicators (32-34) remained at the same performance level as during the last review and will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	173	313	134	269	255			
30	The ISP was revised at least annually.	100% 5/5	1/1	N/A	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

30. Annual ISPs were developed on a timely basis.

31. One of these individuals (Individual #173) had been newly admitted and the IDT held his ISP on a timely basis.

32. ISPs were not consistently implemented on a timely basis, within 30 days of the ISP meeting, for any of six individuals.

In addition, the Monitoring Team found many action plans in these ISPs were service objectives or even just statements that activities would occur, but the Center had no service objective implementation plans. When requested, the QIDP Coordinator stated the Center did not have formal implementation plans for service objectives other than what was included in the ISP action plan tables. He further indicated that the appropriate staff were to be inserviced on the expectations and requirements. When this documentation was requested, the Center reported there was no evidence that these inservices had occurred.

33. Five of six individuals participated in their ISP meetings. The LAR for Individual #255, Denton MHMR, did not allow her to

participate in the ISP annual meeting. The ISP did not make clear how this decision reflected her best interests. Neither individual who could participate in interview (Individual #109 and Individual #255) were knowledgeable of the personal goals, preferences, strengths, and needs articulated in their individualized ISPs. The remaining individuals were not able to participate in this kind of interview.

34. None of six individuals had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. Examples of those did not included:

- For Individual #109's 2016 ISP, no habilitation therapy staff participated, despite ongoing falls. The dietitian did not participate, despite weight loss concerns. Psychiatric staff did not participate, despite significant needs in this area.
- For Individual #255, a vocational representative did not participate, despite the tentative supported employment goal as determined in the ISP Preparation meeting.
- For Individual #269, no habilitation therapy (occupational or physical therapy) staff participated despite repeated falls.

Outcome 6: ISP assessments are completed as per the individuals' needs.

Summary: Performance remained about the same as last time for both indicators, both below criteria. A full set of assessments is needed for the IDT to thoroughly complete its work. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 109	173	313	134	269	255			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	0% 0/5	0/1	N/A	0/1	0/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for none of five individuals. For example, the IDTs did not request falls assessments for several individuals, including Individual #109, Individual #269, and Individual #134. The ISP reviewed for Individual #173 was his initial plan, so no ISP preparation meeting was held.

36. IDTs did not consistently arrange for, and obtain, needed, relevant assessments prior to the IDT meeting. Examples included:

- The IDTs for Individual #269 and Individual #134 had not obtained falls assessments as needed.
- Habilitation therapies staff only completed a screening for Individual #255, even though she was receiving ongoing physical therapy.
- Even when the IDTs identified a needed assessment at the time of the ISP preparation meeting, they were not yet using the period between that time and the ISP annual meeting to ensure assessments were completed as needed. For example, some individuals needed assessments for tentative goals, but these were not completed during the interim period. Instead, they became the initial action plan for the annual ISP or were discarded at that meeting. This meant the IDT did not know whether the tentative goal would be feasible. This could also result in a several-month gap before any actual implementation could

begin. For example:

- Individual #255 had a tentative goal for working as a secretary. The IDT did not obtain a vocational assessment of this need prior to the ISP.
- For Individual #134, the IDT requested the OT to assess her ability to operate television at the time of her ISP preparation meeting, but the Habilitation Therapy assessment did not address this need.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.

Summary: A monthly review of all goals, action plans, and supports is required every month. The QIDPs at Denton SSLC were unable to complete the monthly reviews and, as a result, progress was not assessed, and resultant actions not planned or taken. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	109	173	313	134	269	255			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

Overall, consistent implementation and monitoring of ISP action steps continued to be areas of significant concern. QIDPs were not completing monthly reviews on a regular basis, as described further below.

37-38. IDTs did not review and revise the ISPs as needed, which reflected negatively on the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports. QIDP monthly reviews had been inconsistently completed and provide minimal analysis regarding progress or outstanding needs. There was tendency to cut and paste all or part of observation notes and interdisciplinary progress notes (IPNs) into the monthly review rather than providing a summary and analysis of significant events, trends, and needed follow-up. Follow-up to identified concerns was generally haphazard or absent. Examples included:

- For all individuals, most action plans for personal goals had been infrequently implemented, if at all. In some cases, these unimplemented plans had been continued from one ISP year to the next without identifying and addressing the barriers that prevented implementation. This was true for the ISP observed onsite for Individual #109, for example. The IDT continued goals and action plans for learning to make pizza and working at a pizza restaurant even though there had been no progress and minimal implementation.
- Individual #269 had frequent falls and these had not been assertively addressed by the IDT as detailed above.

It was positive that the Denton SSLC's Quality Assurance Department and administration had identified this serious issue related to QIDP monitoring and had developed some successive corrective actions regarding the QIDP deficiencies. The most recent had been designed just prior to the onsite monitoring visit and was pending actual implementation. It called for each QIDP to have a face-to-face

review of monthly reviews, for all individuals they served, with the Center Director, ADOP and QA Director to determine status and needed follow-up. It was good to see the emphasis being placed on this issue.

Outcome 1 – Individuals at-risk conditions are properly identified.

Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	The individual's risk rating is accurate.	6% 1/18	0/1	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	33% 6/18	0/2	0/2	0/2	0/2	1/2	2/2	2/2	0/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 risk areas [i.e., Individual #313 – dental, and other: bleeding due to Warfarin; Individual #134 – constipation/bowel obstruction, and falls; Individual #92 – skin integrity, and urinary tract infections (UTIs); Individual #186 – dental, and constipation/bowel obstruction; Individual #269 – falls, and dental; Individual #255 – weight, and gastrointestinal (GI) problems; Individual #433 – GI problems, and weight; Individual #507 – constipation/bowel obstruction, and dental; and Individual #349 – skin integrity, and falls].

a. At the time of the annual ISP meeting, Individual #313 was not prescribed Warfarin. Individual #186's IDT effectively used supporting clinical data, and used the risk guidelines when determining a risk level for dental.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #269 – dental; Individual #255 – weight, and gastrointestinal (GI) problems; Individual #433 – GI problems, and weight; and Individual #349 – skin integrity.

The following provide a few examples of changes of status for which IDTs should have met, reviewed the IRRFs, and made changes, as appropriate, but did not:

- In March 2017, Warfarin was added to Individual #313's medication regimen, but the IDT did not update the IRRF and/or develop an IHCP to address the risk of bleeding.
- Based on documentation the Center submitted, in the previous six months, Individual #134 had 11 instances of constipation requiring suppositories. This was a significant change from the IRRF developed at the time of her ISP meeting, which indicated two episodes requiring suppositories in the previous year. However, her IDT did not meet to modify the IRRF and/or the IHCP.

- Individual #134's IDT also did not update the IRRF to address the eight falls that occurred since 12/23/16, and/or the fracture of her right patella on 4/1/17.
- At a dental appointment on 1/13/17, Individual #186 exhibited behaviors that prompted the dentist to recommend dental desensitization and the use of TIVA. The IDT did not update the IRRF, or revise the IHCP.
- Individual #186's IDT did not update the IRRF to include digital disimpaction on 11/28/16, or the enema required due to constipation found on an abdominal x-ray completed on 2/8/17.
- Based on data the Center submitted, Individual #269 had seven additional falls after her ISP meeting on 3/20/17, but the IDT did not update the IRRF.
- Starting in January 2017, Individual #507 had an increase in episodes of constipation, for which there might have been a correlation with episodes of emesis. Although the IDT discussed this possible correlation in ISPA meetings on 1/17/17, and 3/16/17, it did not appear they modified the IRRF.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.

Summary: This outcome requires individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. It was encouraging to see some progress along these lines. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors or to the absence of side effects related to psychotropic medications. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The data will allow the psychiatrist to make data driven decisions

regarding the efficacy of psychotropic medications.

In other words, much like the other SSLCs:

- There need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status.
- The goals need to be measurable, have a criterion for success, be presented to the IDT, appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents, as well as be part of the QIDP's monthly review.

When reviewing psychiatric clinical documentation, there were examples of the psychiatrists identifying target symptoms for monitoring and attempting to write goals. These goals were generally not measurable and were not integrated into the individual's health care plan.

Psychiatric providers attended most ISP meetings. This was good to see and sets the occasion for presentation and discussion, as needed, of psychiatric indicators and psychiatry-related personal goals.

Psychiatric progress notes for quarterly clinical encounters routinely documented review of available data. Unfortunately, the data provided for psychiatry were reportedly unreliable as there were concerns on the part of both the Monitoring Team and facility staff regarding the validity and integrity of data.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Good improvement was demonstrated in CPE format and content. Some improvements remained necessary in ensuring consistent diagnoses across documents and disciplines. Indicators 13 and 14 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
12	The individual has a CPE.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses	56% 5/9	0/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1

	relevant to psychiatric treatment are referenced in the psychiatric documentation.										

Comments:

13. CPEs were completed for all individuals. All of the CPE examples reviewed were noted to include a large volume of information.

14. The Monitoring Team looks for 14 components in the CPE. Eight of the evaluations reviewed addressed all of the required elements. One evaluation, regarding Individual #333, did not include a sufficient bio-psych-social formulation. This individual has significant medical issues that impacted his mental health functioning, and these were not reviewed in the formulation.

16. There were four individuals whose documentation revealed inconsistent diagnoses. For two individuals, Individual #313 and Individual #240, diagnoses were consistent, but there was no current PBSP for review. In the cases of Individual #333 and Individual #202, diagnoses were not consistent across providers. In the case of Individual #333, the most recent psychiatric quarterly review dated 5/23/17 noted diagnoses of an anxiety disorder and pica. Later in the same document, diagnoses were noted to autism spectrum disorder and pica. As such, the diagnoses were not consistent within the same document.

Outcome 5 – Individuals' status and treatment are reviewed annually.

Summary: Although performance scoring was about the same for these three indicators (18, 19, 21), progress was evident as detailed in the comments below. This was good to see and bodes well for improved performance and scoring at the next review. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	29% 2/7	0/1	0/1	1/1	0/1	N/A	N/A	0/1	0/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	67% 6/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	33% 3/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1

Comments:

18. The Monitoring Team scores 16 aspects of the annual evaluation document. Two evaluations met full criteria. The most common deficiencies in the annual evaluations were regarding the psychological assessment/behavioral health assessment and non-pharmacological treatment.

20. During an ISP observed during the monitoring visit, the psychiatrist attended and led the discussion regarding the individual's behavioral health. This was good to see. Also, based on the documents reviewed, it was apparent that the psychiatrists were increasingly involved in leading this discussion during the ISP meetings.

21. Review of the ISP documents indicated that in three more recent examples, there was documentation that met the requirements of monitoring. This was good to see. There was a need for improvement overall with regard to the consistent documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits. There were other examples where some of the required items were included, but generally, the information that was missing was the incorporation of data into the discussion that supports the conclusions. Overall, this area has improved and this was good to see.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

Summary: Three PSPs were reviewed. Various inconsistencies in the various documents that comprised Denton SSLC PSPs were found. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

22. None of the individuals in the review group had a PSP, however, 41 individuals at Denton SSLC had PSPs. Therefore, the Monitoring Team selected four PSPs for review from the list of individuals with a PSP, however, one individual now had a PBSP instead and, so, was not included in this review (Individual #474). Overall, the PSPs included a large amount of relevant information, such as history and current status. The PSP documents also were labeled as PBSPs in various places, contributing to confusion about what was, and what was not, part of the PSP. Criteria for each individual were not met, as described below:

For Individual #166, there was a diagnosis of Bipolar Mood Disorder written in some areas, but the diagnosis was not consistent across all of the documents. There was a notation that there was to be monitoring of insomnia and mood lability as psychiatric symptoms/indicators, but these symptoms/indicators were not mentioned in the PSP portion of the document. The only statement regarding data collection was that it would be done in IRIS.

For Individual #399, the plan included medication plans and stated, in one, that there would be monitoring of rumination and sexual talk. But, in another, there was notation that there would be monitoring of repetitive and jumbled speech, moods unrelated to situation or surroundings, and aggressive behavior. The PSP indicated other symptoms/indicators for monitoring that were not addressed in the medication plans (verbally disruptive behavior, dementia, fetish).

For Individual #404, there was a diagnosis of Bipolar Mood Disorder. The symptoms for tracking were noted as mania (pressured speech, insomnia) and depression (anhedonia, crying spells, isolates self). This was good to see, but there were inconsistencies across the various documents.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

Summary: Three indicators, regarding presence of signed consent, written content, and HRC review were at 100% for this review and with sustained high performance, might be moved to the category of requiring less oversight after the next review. More attention is needed regarding the risk benefit discussion, and to alternate/ non-pharmacologic interventions. The five indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	44% 4/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

29. The facility was including medication information sheets attached to the consent forms. There was some side effect information included on the form, and the attached sheets provided additional information.

30-31. The risk versus benefit discussion was not included in the consent form for five individuals. Four individuals had brief, but sufficient, individualized risk versus benefit discussions included in the consent forms (Individual #313, Individual #333, Individual #459, Individual #173). For non-pharmacological alternatives, the consent forms for three individuals included only the PBSP as an alternative. These individuals were Individual #333, Individual #173, and Individual #630.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Individuals had PBSPs and goals that were, for the most part, measurable and based upon assessments. Measurable goals for counseling supports continued to be an area for improvement, as well as ensuring all problem behaviors were included in assessments. Further, assessments of inter-observer agreement and data timeliness were not occurring as they needed to be. This was also noted as a need at the last review. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

3. All of behavioral health services goals for the individuals were measurable, with the exception of the counseling goals identified for Individual #202.

4. The goals/objectives identified for most of the individuals were based upon their assessments. There were concerns regarding Individual #134 as she was observed engaging in aggression and had a documented history of ingesting scabs, which the team agreed put her at risk of aspiration. Neither of these behaviors were addressed in her PBSP. The one individual who did not have goals/objectives based upon her assessment was Individual #630. It was noted in her functional assessment that she was observed yelling and throwing materials, but neither of these behaviors were addressed in her plan.

5. Data timeliness had not been adequately assessed in the six-month period prior to the onsite visit. Further, inter-observer

agreement was not regularly assessed. Additionally, during the onsite visit, observations were made of individuals engaging in unwanted behaviors. A subsequent check of their PBSP data found that these behaviors were not recorded (i.e., Individual #61 hitting others, Individual #173 making repeated attempts to self-injure). Comments in behavioral health services progress notes also reflected staff concerns regarding the accuracy of reported data.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.

Summary: Behavioral assessments continued to be incomplete or not current or updated. Not all functional assessments were current or updated. On the other hand, functional assessments contained the required content and with sustained high performance, this indicator (12) might be moved to the category of requiring less oversight after the next review. These three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
10	The individual has a current, and complete annual behavioral health update.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
12	The functional assessment is complete.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1

Comments:

10. Only one individual, Individual #173, had a current and complete annual behavioral health assessment. (It should be noted that the staff were awaiting a more recent ICAP from his previous placement.) For three individuals, Individual #333, Individual #240, and Individual #313, the assessment was completed in 2014. For the other individuals, their assessments were current, but did not provide a review of their physical health over the previous year. It should be noted that the facility had developed a Corrective Action Plan to address timely completion of behavioral health assessments.

11. Six of the nine individuals had current functional assessments. The exceptions were the same individuals identified above.

12. The functional assessment for eight individuals was complete. Staff are advised to give the specific dates during which indirect and direct assessments were completed. Although it was noted in Individual #202's behavioral health assessment that indirect/anecdotal assessments would be completed six months after his admission, the facility reported that these had not been completed. It was noted that Individual #173 was being seen in the Behavior Analysis Resource Center (BARC) with plans to complete a functional analysis. As noted in his integrated behavioral health assessment and as reported by staff, current activities included completion of a preference assessment (food) and rapport building.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.

Summary: There was improvement in PBSP implementation timeliness, but there was no improvement in PBSPs being updated, and no improvement in the content of the PBSPs, especially when considering aspects of each individual's life at Denton SSLC and as detailed in the comments for indicator 15 below. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. There was evidence that, for eight of the individuals, the PBSP in place at the time of the onsite visit had been implemented within 14 days of all consents. The exception was Individual #333 whose consent tracking information referenced a plan implemented in April 2017. This suggested that the plan was implemented before HRC consent had been obtained.

14. The PBSP was current for six of the nine individuals. The exceptions were Individual #333, Individual #240, and Individual #313, whose plans were implemented in 2014. Of the 235 individuals included on the facility's master list, 60 (26%) had PBSPs that were overdue (completed between 8/11/13 and 4/22/16).

15. None of the PBSPs were considered complete. Missing from all were the use of positive reinforcement in a manner that was likely to be effective, and sufficient opportunities for replacement behaviors to be trained or strengthened. Individual specific comments are outlined below.

- Staff are advised to discontinue the use of the term "junk" behavior. Not only is this disrespectful to the individual, but it requires staff interpretation which could result in inconsistencies in staff response and plan implementation. This has been mentioned in previous monitoring reports.
- Individual #333: At an ISPA meeting held in January 2017, the IDT recommended adding biting to the aggression definition and initiating the collection of data on self-injury. There was no evidence that the PBSP had been revised to address these matters. His PBSP summary did identify self-injury as a problem behavior, but this was not in the PBSP.
- Individual #109: A response cost contingency was in place for his property destruction. An extra outing was contingent upon his showering a designated number of times in one week, but there were no baseline data available to assess the efficacy of this plan. The behavioral health assessment reviewed at his ISP meeting (held during the onsite visit and observed by the Monitoring Team) indicated that there were no restrictive practices in his PBSP, however, a response cost contingency was then described and reviewed.

- Individual #459: False allegations were one of the behaviors tracked in her plan. As DFPS had agreed to conduct streamlined investigations with this individual, the facility was expected to develop a data-based plan to reduce this behavior, per state policy. When asked about this plan, the director of behavioral health services noted that allegations were tracked via DFPS investigations/outcomes and reported in her monthly progress note. The PBSP included guidelines for minimizing reinforcement of this behavior. There were no other plans for reducing this behavior. The director of behavioral health services was advised to review this plan with the State Office discipline coordinator for behavioral health services to ensure this met the guidelines stipulated in the policy.
- Individual #173: This individual was admitted to the facility in early January 2017. At the time of admission, he was wearing a helmet and arm splints. Although the helmet was discontinued at admission, he continued to wear the splints except when showering. This was referenced as a medical restraint plan (ISPA data 1/26/17) to promote healing to a wound on his head. However, the splints were actually a protective mechanical restraint for self-injurious behavior (PMR-SIB).
- Individual #202: An ISPA, dated 5/4/17, indicated that the IDT had agreed to a restrictive practice to address his refusals to shower and attend scheduled work. Specifically, Individual #202 would not be able to contact his family unless he had showered and attended work for three consecutive days. This strategy was put in place without HRC approval and without baseline data to assess his current level of performance and the efficacy of the intervention. The need for consent was not identified until the Monitoring Team requested this information. This resulted in an emergency referral to the HRC. When observing the meeting, it was reported that the IDT had held an ISPA meeting the previous day (6/27/17) during which time this matter had been discussed. When minutes from this meeting were requested, the facility reported that a meeting had not been held (it was further reported that this had been entered into Care Tracker in error). Further concerns were raised because Individual #202 had reported to his counselor as early as 3/17/17 that he was not comfortable taking a shower at the facility. One reason given was the lack of cleanliness of the bathroom. When this was discussed with the team, it was recommended that shower shoes and a mat be purchased for him. These materials were not purchased until 6/2/17. There was no documentation of discussion of other variables (e.g., time of day, materials used) that could make showering more comfortable for Individual #202, nor was there any evidence of other strategies to help him complete this daily routine.
- Individual #313: One of the targeted behaviors in his PBSP was bucking in his wheelchair. At an ISPA meeting on 5/3/17, it was noted that he seemed to engage in this behavior less often when able to sit in a large, comfortable recliner. The physical therapist was to implement a positioning schedule. When this was requested while onsite, a copy of his PNMP was provided. This noted that he should be allowed to sit in a recliner when at home, but no schedule was specified.
- Individual #134: Individual #134 was observed on several occasions by the Monitoring Team. Each time, she was observed hitting staff. When staff were interviewed, it was reported that she will also head butt. Aggression was not addressed in her plan. Even more concerning was the absence of pica, specifically the ingestion of scabs. At an ISPA meeting, it was noted that this behavior put her at significant risk of aspiration. As such, it should be included in her PBSP. The only behavior identified for reduction in her plan was self-injury. This behavior was documented only if she caused a tear to her skin or required treatment. This requirement will likely result in an under-reporting of the behavior. Further, when staff were asked how they collected data on self-injury, it was reported that nurses collected these measures after direct support professionals alerted them to an injury.
- Individual #630: The most recent PBSP progress note included an observation by behavioral health services staff of frequent nonfunctional screaming. This behavior was not addressed in her PBSP.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: Indicator 25 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
Comments: 25. Only Individual #202 was participating in counseling at the time of the visit. While his counseling plan and progress note referenced objectives, these were not measurable. A criterion for review and revision of his plan was identified, as were steps that would be taken to address generalization of skills learned. There was no reference provided to indicate that evidence-based practices that were in use.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. Indicator c will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. Moreover, in response to the Monitoring Team's requests for these reviews, the Center indicated: "Provider no longer does quarterly reviews. The Facility now does Interval Medical Reviews every six month." This reflected											

a misinterpretation/misunderstanding of the requirements.

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual receives quality AMA.	33% 3/9	1/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that three individuals' AMAs (i.e., Individual #313, Individual #186, and Individual #433) included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, lists of medications with dosages at the time of the AMA, and plans of care for each active medical problem, when appropriate.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #313 – respiratory compromise, and cardiac disease; Individual #134 – respiratory compromise, and gastrointestinal (GI) problems; Individual #92 – respiratory compromise, and GI problems; Individual #186 – GI problems, and cardiac disease; Individual #269 – weight, and falls; Individual #255 – diabetes, and weight; Individual #433 – GI problems, and osteoporosis; Individual #507 – GI problems, and weight; and Individual #349 – seizures, and falls].

As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0/18									
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #313 – respiratory compromise, and cardiac disease; Individual #134 – respiratory compromise, and GI problems; Individual #92 – respiratory compromise, and GI problems; Individual #186 – GI problems, and cardiac disease; Individual #269 – weight, and falls; Individual #255 – diabetes, and weight; Individual #433 – GI problems, and osteoporosis; Individual #507 – GI problems, and weight; and Individual #349 – seizures, and falls). In many instances, plans of care defined in individuals' annual medical assessments were not carried forward in their IHCPs. b. As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: During this review, improvement was noted with regard to the timely completion of annual dental exams and annual dental summaries. While maintaining this progress, the Center should continue its focus on improving the quality of dental exams and summaries.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A			N/R						
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	88% 7/8	1/1	0/1		1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 8/8	1/1	1/1		1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	33% 3/9	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1	1/1
c.	Individual receives a comprehensive dental summary.	63%	1/1	1/1		1/1	1/1	0/1	0/1	0/1	1/1

		5/8									

Comments: a. Individual #92 was edentulous, and was part of the outcome group, so a limited review was conducted. It was positive that generally individuals reviewed had timely dental exams and summaries. On 9/22/16, the dentist attempted to complete an annual dental exam with Individual #134, but the appointment was unsuccessful. At the time of the review, an exam had not been completed. The anesthesiologist determined that hospital dentistry was needed to safely administer TIVA to Individual #134.

b. It was positive that for Individual #92, Individual #433, and Individual #349, all of whom were edentulous, the dental exams included all of the required components. It was also good to see that all of the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- Sedation use;
- Periodontal charting;
- An odontogram; and
- A treatment plan.

Most, but not all included:

- An oral cancer screening;
- An oral hygiene rating completed prior to treatment;
- A description of periodontal condition;
- Caries risk;
- Periodontal risk;
- Specific treatment provided; and
- The recall frequency.

Moving forward, the Center should focus on ensuring dental exams include, as applicable:

- Information regarding last x-ray(s) and type of x-ray, including the date; and
- A summary of the number of teeth present/missing.

c. Overall, it was good to see continuing improvement with the quality of the dental summaries. Problems varied with the summaries that did not meet criteria. For example:

- The dentist did not complete the template with regard to the need for a desensitization program (or not) for Individual #255.
- Individual #433 was edentulous, but the dental summary indicated 32 teeth were present.
- Individual #507's dental summary did not provide a complete list of treatments provided.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: Due to issues with IRIS, full physical assessments were not documented for a number of individuals (i.e., often weight graphs, fall assessments, and	Individuals:

assessments of reproductive systems, and in some cases, Braden scores related to skin integrity were missing). The remaining indicators require continued focus to ensure nurses complete timely quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.											
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	22% 2/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/17	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/7	N/A	0/2	0/1	0/1	0/1	N/A	N/A	0/1	0/1

Comments: a. Problems were noted for seven of the nine individuals with regard to a lack of complete annual physical assessments, including weight graphs, fall assessments, and assessments of reproductive systems, and in some cases, Braden scores related to skin integrity. Similar problems were noted with quarterly physical assessments. This largely appeared to be due to issues with IRIS. The nurses on the Monitoring Team have discussed this issue with the State Office Nursing Discipline Lead, and work is underway to correct the issues. In addition, for some individuals, some quarterly assessments were not completed/submitted or were completed late.

b. For nine individuals, the Monitoring Team reviewed a total of 17 IHCPs addressing specific risk areas [i.e., Individual #313 – dental; Individual #134 – constipation/bowel obstruction, and falls; Individual #92 – skin integrity, and urinary tract infections (UTIs); Individual #186 – dental, and constipation/bowel obstruction; Individual #269 – falls, and dental; Individual #255 – weight, and gastrointestinal (GI) problems; Individual #433 – GI problems, and weight; Individual #507 – constipation/bowel obstruction, and dental; and Individual #349 – skin integrity, and falls].

At the time the annual nursing assessment was completed, Individual #313 was not prescribed Warfarin. None of the nursing

assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. The following provide a few of examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- A review of the Dietary documentation for Individual #134 indicated that there were/are a number of issues related to the tracking of enteral feedings, water intake, and residuals. According to the Dietician's notes, issues included; 1) on 2/6/17, Individual #134 was not provided her ordered enteral nutrition (Diabetisourse AC) since the floor nurse did not have any for the evening feeding. Central Kitchen did have the formula, but was not contacted when the home ran out; 2) according to the PNMT RN, a new order for trial feeding was not transcribed to the Medication Administration Record (MAR); 3) the Floor RN reported to the Dietician that Individual #134 was getting 300 milliliters (ml) of water with her overnight feeding, although it had been discontinued on the 2/17/17 diet order, but not removed from the MAR, and nursing staff were not initialing it as being administered on the MAR; 4) based on the Dietician's calculations related to the reordering schedule and the actual number of cases of formula that were unused in March 2017, Individual #134 was not being given the correct amount of formula on a daily basis; 5) the MAR listed five different hours to provide formula and fluids, when there should have been only three, and it listed four different hours to provide Duocal when there should have only been one administration time; and 6) only two scoops of the Duocal were being provided, when it should have been two cups. In addition, a review of the Enteral Feeding Record for this individual for three months found most entries did not include the month/year and all had a significant number of blanks for the administration of the formula, water, and if residuals were assessed and the specific amount of residual obtained. There was no way to determine from the documentation what the individual's total intake amount was each day and how much residual was present, especially when her formula was being titrated for tolerance, weight gain, constipation issues, and nutritional status. In addition, Center staff indicated that the May 2017 residual data for this individual could not be located. Based on review of the nursing documentation, nursing staff did not initiate any ongoing assessments to address a number of Individual #134's risks that these issues could have impacted, including her risk for constipation [e.g., the 11 episodes of constipation warranting pro re nata (PRN, or as-needed) suppositories], as well as emesis, medication levels, weight issues, falls, and her overall nutrition.
- An IPN, dated 4/1/17, noted Individual #134 fell down head first in 512A. In the note, the nurse did not mention the individual's mental status or injuries to her head, whether or not she had a headache, or the results of an initial neurological check. The note also indicated that Individual #134 had pain rated as "8" with activity, but it did not describe how she showed pain or where the pain was.
- An IPN, dated 11/13/16, noted Individual #92 had an oval open area to his right buttocks. The skin assessment was not complete in that it did not include the temperature of the skin, color, presence or absence of odor, description of borders, description of where the area was, and/or any issues noted on other areas of the individual's skin.
- On 2/28/17, Individual #269 fell, was sent to the ED, and had two staples placed in the back of her head. On 3/1/17, the nurse noted in an IPN that Individual #269 complained of a headache. The IPN did not reflect a complete assessment of her head pain, especially after sustaining a significant injury from a very recent fall. Issues not assessed included: mental status,

gait, neurological checks, visual issues, location of the pain, nausea, dizziness, lethargy, and any confusion.

- For at least the past two years, Individual #507 had been having significant episodes of vomiting as well as an increase in episodes of constipation. A review of the paper Medication Records for the past three months found a significant number of blanks on each page related to residuals, and water intake during medication administration and formula administration. This was very concerning since the documentation of this information is a standard of proactive practice and provides critical clinical information.
- On 2/3/17, IPNs addressing Individual #349's fall with a laceration to his right forehead did not include complete assessments of his status. Assessments lacked: description of the seizure, assessment of the pupils, level of consciousness changes, on-going mental status, deformities to the skull, minimalizing movement, temperature of the skin, status of the bleeding from the facial laceration, how the individual was transported to the hospital, and what information was reported to the receiving facility and who took it.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

Summary: Given that over the last four review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: b and c. The IHCP that included preventative measures was for Individual #186 for constipation/bowel obstruction. It included an intervention for nurses to assess the individual for abdominal distention and measure abdominal girth. This was a good

start, but should be expanded to include assessment of the individual's bowel sounds and intake, and the assessments should be done more frequently than quarterly as noted in the IHCP.

The following provide two examples of a number of concerns related to the lack of sufficient action plans to address individuals' needs and minimize their risk to the extent possible:

- Individual #433's IDT should have developed and implemented a specific IHCP for Hepatitis C. It should have addressed infection control issues, as well as monitoring Individual #433 for side effects of the treatment/medication prescribed for the Hepatitis C. Interventions for neither of these components were included in the IHCP provided.
- Of significant concern, Individual #349 was not only at risk for falls, but actually fell 12 times since December 2016 (if the data provided to the Monitoring Team was accurate). In addition, two of these falls resulted in staples and sutures to his head. One of these falls occurred in the month prior to the ISP meeting. However, the IDT still did not include any nursing interventions in the IHCP for falls. Overall, the IDT showed a lack of urgency in addressing Individual #349's falls.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.

Summary: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. IDTs need to improve the timely referral of individuals to the PNMT, and/or the PNMT needs to make self-referrals. The Center also should focus on completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, particularly Behavioral Health Services staff, and the quality of the PNMT reviews and comprehensive assessments. All of these indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	38% 3/8	0/1	0/1	0/1	1/1	0/1	N/A	1/1	1/1	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1		N/A	N/A	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	33% 1/3	N/A	0/1	0/1	N/A	N/A			1/1	N/A
d.	Based on the identified issue, the type/level of review/assessment	14%	0/1	0/1	0/1	0/1	0/1			1/1	0/1

	meets the needs of the individual.	1/7									
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 6/6	1/1	1/1	1/1	1/1	N/A			1/1	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/7	0/1	0/1	0/1	0/1	0/1			0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/5	0/1	N/A	0/1	0/1	0/1			N/A	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3	N/A	0/1	0/1	N/A	N/A			0/1	N/A

Comments: a. through d., and f. and g. For the eight individuals that should have been referred to and/or reviewed by the PNMT:

- Since January 2017, Individual #313 had a declining ability to swallow safely. In January 2017, a dysphagia assessment recommended a ground texture diet with thin liquids. By March 2017, it was recommended he receive nothing by mouth (NPO), followed by a recommendation for a pureed texture diet with nectar-thick liquids. In May 2017, he had another modified barium swallow study (MBSS) that recommended NPO again. The PNMT held only one meeting with the IDT, and this did not occur until 5/3/17. No PNMT minutes or notes were found showing discussion of Individual #313's laryngeal fracture. The fracture occurred in March 2017, which was after the decline in swallowing function already was noted, so the cause of the decline could not be attributed solely to the laryngeal fracture. The PNMT should at least have conducted a review.
- On 7/22/16, 11/19/16 and 4/16/17, Individual #134 had aspiration pneumonia, but the PNMT did not conduct a review or assessment. Individual #134 was referred to the PNMT for weight. Due to the multiple episodes of aspiration pneumonia, fractures, falls, increased emesis, and weight loss, a comprehensive assessment was warranted. While there were PNMT notes, none of these met the need for a comprehensive assessment.

  In its comments on the draft report, the State questioned the finding that Individual #134 was not referred within five days of a qualifying event. However, in the documents the State referenced, which the Monitoring Team reviewed for a second time, no evidence was present of a referral to the PNMT for Individual #134's aspiration pneumonia events, even though she was referred for other qualifying events.
- Individual #92 was referred to the PNMT for weight issues, and was referred to the PNMT numerous other times. Between 3/17/17 and 3/28/17, the PNMT conducted an assessment. However, prior to this, Individual #92 had multiple pneumonias, including a diagnosis of aspiration pneumonia on 1/13/17. The PNMT stated that criterion was not met due to aspiration

pneumonia occurring at the hospital, but this decision was not consistent with policy, which states that the PNMT should at least review any diagnosis of aspiration pneumonia. It was not until 2/23/17, when Individual #92 was diagnosed with pneumonia again, that the PNMT initiated an assessment.

In its comments on the draft report, the State questioned the finding that Individual #92 was not referred within five days of a qualifying event. However, in the documents the State referenced, which the Monitoring Team reviewed for a second time, no evidence was present of a referral to the PNMT for Individual #92's aspiration pneumonia on 1/13/17. As stated in the draft report, Individual #92 was not referred for the January pneumonia, and the PNMT did not conduct a comprehensive assessment to address the aspiration pneumonia, until after Individual #92 had a second pneumonia event a little over a month later.

The PNMT did not conduct at least a review for Individual #92's aspiration pneumonia.

- On 12/15/16, Individual #186 was diagnosed with aspiration pneumonia. She was referred timely to the PNMT. A PNMT note was present, but did not meet the requirements of a review.
- Between December 2016 and March 2017, Individual #269 fell nine times. However, her IDT did not refer her to the PNMT, and the PNMT did not make a self-referral.
- Individual #433 was referred to the PNMT for an assessment, but the PNMT was unable to provide the assessment due to his hospitalization and eventual death.
- Individual #507's IDT referred her to the PNMT to address emesis. The PNMT made the decision to forego a review, and moved straight to conducting an assessment. Given that the emesis potentially had a behavioral component, it was unclear why Behavioral Health Services staff were not part of the PNMT assessment process.
- On 10/10/16, Individual #349 was diagnosed with pneumonia, but the PNMT did not conduct a review, and had fallen multiple times. Minutes from the PNMT stated that the PNMT SLP attended the ISP meeting and all supports and services were appropriate, but no detail was provided regarding what these supports were and how they were determined to be sufficient.

  In addition, Individual #349 was not referred to the PNMT to address unresolved falls. Criterion for referral is when an individual has three or more falls for two consecutive months. Between December 2016 and March 2017, criterion was met three times, but the IDT did not hold an ISPA meeting with the PNMT to discuss his falls.

e. It was positive that as needed, a RN Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results.

h. As noted above, Individual #134 should have had a comprehensive PNMT assessment, but did not. The following summarizes some of the concerns noted with the two assessments that the PNMT completed:

- Although the PNMT assessments for Individual #92 and Individual #507 included a summary of team members' observations, they lacked thorough assessments of their current physical status [e.g., musculoskeletal status, respiratory status, skin integrity, posture and alignment, positioning, motor skills, transfers, activities of daily living (ADLs), residual thresholds (as indicated), lab work, nutritional status (weight, height, needs), and oral hygiene status].
- The PNMT recommended Behavioral Health Services staff become involved in addressing both Individual #92 and Individual

#507's needs. However, given that the PNMT identified potentially significant behavioral components to the issues assessed, it was unclear why they did not involve Behavioral Health Services staff in the PNMT assessment processes.

- Evidence, including data, was not present in either assessment to substantiate whether or not current supports and services were effective.
- The PNMT did not recommend clinically relevant, measurable goal/objectives for either individual. Although the PNMT identified a new threshold related to aspiration, it was not integrated into Individual #92's IHCP.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.

Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. All of these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	11% 2/18	0/2	1/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	22% 2/9	0/2	0/1	1/1	0/1	1/1	N/A	0/1	0/1	0/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: choking, and aspiration for Individual #313; aspiration, and weight for Individual #134; weight, and aspiration for Individual #92; skin integrity, and aspiration for Individual #186; choking, and falls for Individual #269; falls, and constipation/bowel obstruction for Individual #255; falls, and aspiration for Individual #433; aspiration, and GI problems (emesis) for Individual #507; and aspiration, and falls for Individual #349.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT

assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks.

c. All individuals reviewed had PNMPs and/or Dining Plans. Some of the problems noted included:

- Many of the PNMPs/Dining Plans did not list triggers or omitted important triggers (e.g., pica);
- For some individuals, pictures of beds on the PNMPs did not include the individual in the bed; and
- None of the PNMPs referred to Communication Dictionaries, or for one individual, the need to have staff available who are able to communicate using sign language.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for weight for Individual #134, and aspiration for Individual #92.

f. The IHCPs that identified triggers and actions to take should they occur were those for GI problems for aspiration for Individual #92, and choking for Individual #269.

g. The IHCPs reviewed did not include the frequency of PNMP monitoring.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/3	N/A	0/1	0/1	N/A	N/A	N/A	N/A	0/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/2		N/A	0/1					0/1	

Comments: a. and b. For Individual #134, the IDT indicated that they were considering increasing tube feedings, but provided no further discussion. With regard to plans to return to oral intake, the IRRF only stated that she had history of severe dysphagia, but offered no details regarding what had been done in the past. For example, there was no discussion of whether or not there had been trials with bolus, or whether this would be clinically safe and appropriate. Currently, staff placed Individual #134 in a wheelchair for her feedings, since she has a tendency to often walk around.

With regard to Individual #92's potential to return to oral intake, the IRRF only stated that he would be free from pneumonia for a year before being provided a snack. An MBSS recommended he continue PO intake. Therefore, it was unclear why a year was chosen as the benchmark. Also, it had not been determined if PO intake resulted in pneumonia for Individual #92. For Individual #507, the IRRF section on the potential to return to oral intake stated that she would consume 80% of her snack for three months before progressing. No evidence was found of data or analysis of data to determine her progress. Moreover, it was unclear how the IDT determined 80% over three months was the appropriate goal.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	67% 6/9	0/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	33% 3/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills,	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A

	oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/4	0/1	0/1	N/A	N/A	N/A	N/A	0/1	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/5	N/A	N/A	0/1	0/1	0/1	0/1	N/A	N/A	0/1

Comments: a. and b. The following concerns were noted:

- Individual #313's ISP noted that the IDT made a request for the OT to complete an upper extremity assessment by 3/24/17, to determine if he could handle a pitcher of fluids. The Center did not submit documentation to show this occurred. In addition, in May 2017, the IDT recommended that the OT/PT assess his head-of-bed elevation, but no evidence was found to show the OT/PT completed this assessment. In addition, Habilitation Therapy staff were to develop a positioning schedule for Individual #313, but there was no evidence it was developed outside of the PNMP that simply stated "to allow him to sit in recliner when home."
- For Individual #134, after a 2/27/17 PNMT note, no evidence was found that the OT/PT completed an assessment of Individual #134 using the reacher. Notes from the OT/PT were not consistent with each other. More specifically, a note, dated 4/11/17, stated that Individual #134 was improving, and that the OT would modify the reacher and continue to work with her. A second note, which was not integrated into IRIS until the Monitoring Team made a request, stated that she refused to use the reacher multiple times. This resulted in a negative score for Indicators a and b.
- For Individual #92, and Individual #186, the 2016 updates did not provide clear statements regarding when the next comprehensive assessments should be completed (i.e., should they have been completed for the individuals' 2017 ISPs).
- The OT/PT completed an annual update for Individual #269, dated 2/24/17, that stated potential causes of the falls were her behavior, fluctuating gait, and poor safety awareness. However, the OT/PT did not complete a consultation when the falls continued to occur. This resulted in a negative score for Indicators a and b.
- Despite the fact that Individual #255 received direct PT therapy and used a walker, the OT/PT only completed a screening.

c. Individual #255's screening lacked a recommendation for further assessment due to her use of adaptive equipment and participation in direct therapy.

d. The Monitoring Team reviewed comprehensive OT/PT assessments for four individuals. Overall, many problems were noted with the assessments reviewed. The following summarizes some of the problems noted:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: None of the assessments reviewed included the individuals' health risks, levels of risk, and potential impact or correlation with OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For all four individuals, the assessors listed medications, but did not discuss whether or not medications were potentially impacting an OT/PT problem(s);
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living: For one individual, there was no clear assessment of transfer ability or gait, and another assessment did not provide a functional description of the individual's ability to participate in daily tasks;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): Individual #313's assessment described his bucking behavior and the need for a tilt-in-space wheelchair, but did not provide additional information regarding fit, especially since he self-propels his wheelchair ;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: Three of the assessments reviewed did not provide a comparative analysis that went beyond general statements;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: None of the assessments met this criterion. Problems included a lack of monitoring findings, a lack of data to confirm the effectiveness of supports, and/or a lack of discussion about and/or revisions to supports that were not effective at minimizing or preventing PNM issues, such as falls, etc.;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: A number of assessments identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations. The only assessment that met criterion was the one for Individual #433; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address individuals' needs were not.

On a positive note, all of the comprehensive OT/PT assessments the Monitoring Team reviewed included, as applicable:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs; and
- The individual's preferences and strengths were used in the development of OT/PT supports and services.

e. As discussed above, Individual #255 should have had at least an update conducted, but did not. For the four OT/PT updates reviewed, the following summaries some examples of concerns noted:

- The individual's preferences and strengths are used in the development of OT/PT supports and services: For two individuals, OT/PT goals or programs were not developed based on their preferences and strengths;

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: For three individuals, the assessors only stated that certain risks were increased, but did not provide the level of risk;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: All four updates merely stated that "pertinent" medications were reviewed and no issues were noted. The updates provided no information regarding which medications were pertinent or why;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day: Two of the updates did not provide details regarding the individuals' use of skills throughout the day;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: The gait section for Individual #349 was vague and did not assess gait pattern, etc.;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: None of the updates met this criterion. Problems included a lack of monitoring findings, a lack of data to confirm the effectiveness of supports, and/or a reliance on an absence or presence of overt outcomes to determine effectiveness (e.g., choking, aspiration pneumonia, fractures, etc.);
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Because individuals often did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. In other instances, justification was not provided for not developing OT/PT supports to address identified needs; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: As noted above, updates often did not include recommendations to address strategies, interventions, and programs necessary to meet individuals' needs. The only exception was for Individual #349.

On a positive note, as applicable, all of the updates reviewed provided:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs; and
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.

Summary: It was good to see improvement from the last review with regard to IDTs reviewing and making changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349

a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	67% 6/9	1/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	50% 2/4	N/A	1/1	0/1	0/1	N/A	N/A	N/A	N/A	1/1

Comments: a. Individual #255 and Individual #433 had participated in direct therapy, but their ISPs did not include updated information regarding their functional status based on these interventions (i.e., the status of the programs).

c. and d. Examples of concerns noted included:

- Individual #255 and Individual #433's ISPs did not reference their direct therapy programs.
- Individual #92's IDT did not hold an ISPA meeting to discuss the results of the OT/PT consultation on recliner and bed positioning.
- Individual #186's IDT did not hold an ISPA meeting to discuss the results of the HOBE evaluation.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: In addition to improving screenings to ensure that individuals who need more extensive assessments receive them, the quality of communication updates should be an area on which the Center focuses. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									

	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	33% 3/9	1/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/5	N/A	0/1	N/A	N/A	N/A	0/1	0/1	0/1	0/1
d.	Individual receives quality Comprehensive Assessment.	N/A									
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/7	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A

Comments: a. and b. The following provides information about problems noted:

- On 8/15/13, Individual #186's last communication assessment was completed. The Speech Language Pathologist (SLP) noted a decline in Individual #186's skills, but offered no SAP or goal development to address the regression. Due to the decline, subsequent assessments/updates should have occurred.
- SLPs completed screenings for Individual #134, Individual #255, Individual #433, and Individual #507, but given their deficits in receptive and expressive language, and/or reading, comprehensive assessments or updates were warranted.
- The SLP completed Individual #349's communication screening on 5/4/17, but his ISP was dated 3/23/17. The screening did not address his higher level cognitive components and executive functioning skills.

c. Screenings that should have made recommendations for more extensive assessments did not. Other problems noted included a lack of discussion of medications and their impact on communication, and in some cases, limited descriptions of expressive and receptive communication.

d. Because of the age of Individual #186's comprehensive assessment (i.e., close to four year's old), it was not audited for purposes of this review.

e. As noted above, Individual #134, Individual #255, Individual #433, and Individual #507 should have had updates completed, at a minimum, but did not. The following provides a description of the requirement and examples of concerns noted with regard to the required components of the three communication updates the Monitoring Team reviewed:

- The individual's preferences and strengths are used in the development of communication supports and services: The updates identified communication strengths, but then did not recommend programs or strategies to build upon these strengths;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Two of the updates provided either no review of medications, or stated that "pertinent" medications were reviewed and no issues were noted, but provided no information regarding which medications were pertinent or why;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Individual #269's update referenced a "sign group," but provided no data or analysis to describe any improvements that resulted from her participation in the group. Individual #313's update provided no discussion of expansion of his current skills;
- The effectiveness of current supports, including monitoring findings: None of the updates included monitoring findings, and/or analysis of data to support the effectiveness of current supports;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: Updates either did not investigate the use of AAC devices or systems, or did not reflect thorough assessment of AAC options, including detailed descriptions of previous attempts; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Without complete AAC assessments, as discussed above, recommendations could not be fully developed. For each individual, deficits as well as strengths were noted, but the SLPs often did not offer recommendations to build upon the individuals' strengths to develop communication programs and expand existing skills.

On a positive note, the updates sufficiently addressed:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: a. through c. It was positive that ISPs reviewed included descriptions of how the individuals communicate and how staff should communicate with the individual. This represented progress from previous reviews. Work was needed to ensure ISPs clearly summarized IDTs' discussion about Communication Dictionaries, and addressed strategies, interventions, and programs that SLPs recommended in their assessments.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
Summary: Improvements were seen in indicators 3 and 4, that is, regarding SAPs being based upon assessments and being practical, functional, and meaningful. Reliable and valid data, however, were not collected or assessed. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the									

2	The SAPs are measurable.	category of requiring less oversight.									
3	The individual's SAPs were based on assessment results.	74% 20/27	3/3	3/3	0/3	2/3	3/3	1/3	2/3	3/3	3/3
4	SAPs are practical, functional, and meaningful.	63% 17/27	3/3	2/3	0/3	3/3	2/3	0/3	2/3	2/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
3. For each individual, three SAPs were chosen for this review. Twenty of these 27 SAPs were based on assessments. Where there were exceptions, the individual's functional skills assessment noted the individual could perform the skill or basic components of the skill.

4. Seventeen of the 27 SAPs were considered practical, functional, and meaningful. In addition to those SAPs that addressed skills the individual had already mastered, exceptions included the following: Individual #109 and Individual #202 each had a SAP to work continuously, yet this clearly addressed a matter of compliance rather than new skill development; Individual #459 was to learn to use the computer, but her identified goal was to facilitate or teach a Zumba class; another one of Individual #459's goals was to re-establish her relationship with her family, but the SAP required her to verbally identify appropriate things she could do with staff; Individual #173 was to learn to identify colors to help him learn about his medications; and Individual #134 was to learn to fold a paper in thirds. Given that the goal was to re-establish her relationship with her mother, it might be more functional to teach her to Skype or to sign (using a name stamp) and mail a greeting card.

5. The facility had just recently developed a plan for assessing SAP integrity, including the reliability of the data. At the time of the onsite visit, none of the SAPs had been the subject of this assessment process.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

Summary: Overall, performance was about the same as during the last review. To be specific, indicator 10 improved to 100%, indicator 11 decreased slightly, and indicator 12 remained the same. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9	1/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:
10. All of the individuals had assessments that were current with the ISP that was reviewed. Several individuals, however, had a day program assessment completed in lieu of a vocational assessment. While this may be appropriate for those who are at or near retirement age and are not interested in working (e.g., Individual #134 and Individual #630), for others (e.g., Individual #333 and Individual #313) involvement with work activities may be an area of interest if they were exposed to this opportunity. Certainly for younger individuals, such as Individual #240 and Individual #173, consideration should be given to assessing their work interests and skills.

11. A comparison was made between the dates of the individual's assessments and their ISPs. This revealed completion of assessments at least 10 days prior to the scheduled ISP for five individuals (Individual #333, Individual #109, Individual #459, Individual #240, Individual #313). The facility's tracking indicated that the functional skills assessment was not provided on time for the first three of these individuals. Further discrepancies were noted as the facility indicated that the assessments for Individual #173 and Individual #202 were provided on time, while the Monitoring Team identified these as late.

12. For eight of the nine individuals, the functional skills assessment and vocational/day program assessments included recommendations for skill acquisition. The exception was Individual #173, whose day program assessments lacked any SAP recommendations. As has been noted previously, the functional skills assessment evaluates one's skills across a broad range of domains. As such, it could indicate a vast number of skills that would benefit the individual and enhance his or her quality of life.

Domain #3: Individuals in the Target Population will achieve optimal physical, mental, and behavioral health and well-being through access to timely and appropriate clinical services.

This domain contains 38 outcomes and 169 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 16 of these indicators, including one entire outcome, had sustained high performance scores and moved to the category requiring less oversight. Presently, three additional indicators will move to the category of less oversight in psychiatry, and dental. Two indicators in behavioral health/psychology, and medical will return to active oversight.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Goals/Objectives and Review of Progress

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Regarding crisis intervention restraint usage more than three times in any rolling 30-day period, IDT discussions were not including the content required by indicators 20 to 23.

Psychiatry quarterly reviews were completed quarterly, but continued attention to the content is needed.

Individuals were reviewed by polypharmacy committee. Polypharmacy meeting was well-attended and included thorough reviews of medication regimens meeting criteria for polypharmacy.

In behavioral health services, given the absence of good, reliable data, progress could not be determined for all of the individuals. When the facility's data showed that goals were obtained, teams did not update or make new objectives. Similarly, there was no evidence that IDTs initiated corrective action plans to address any worsening performance.

It was good to see that behavioral health services progress notes now commented upon the progress of the individual. Graphic summaries, however, continued to be done in a way that was not useful for making treatment decisions. Peer reviews were occurring, some more frequently than the minimum requirements, some less than the minimum requirements.

Acute Illnesses/Occurrences

Based on interview with the Chief Nurse Executive (CNE), nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

With regard to acute illnesses and events, it is important that medical providers conduct and document thorough assessments. In addition, when individuals are transferred to the hospital, the PCP or a nurse needs to communicate necessary clinical information to hospital staff. It was positive that for most acute issues, medical providers conducted necessary follow-up.

In psychiatry, without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals.

Implementation of Plans

Treatment was coordinated between psychiatry and behavioral health clinicians, though two PBSPs had not been updated. There was good and regular collaboration between psychiatry and neurology.

Regarding monitoring for side effects of psychotropic medications, most criteria were met, but the high performance seen at the last review was not maintained.

Insufficient numbers of staff were shown to be properly trained in the PBSPs. The facility had not maintained BCBA supervision of PBSP documents as required.

In previous reviews, indicators regarding the data collection systems for PBSPs met criteria, but perhaps due to changes in the electronic data system, criteria were not met for this review. Ensuring PBSP reliability and implementation integrity needed more attention, too.

As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports due to lack of inclusion of regular assessments in alignment with nursing guidelines and current standards of care. As a result, data often were not available to show implementation of such assessments. In addition, for the individuals reviewed, evidence was generally not provided to show that IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

Work is needed to ensure that PCPs address individuals' chronic or at-risk conditions by completing medical assessments, tests, and evaluations consistent with current standards of care, and identifying the necessary treatment(s), interventions, and strategies, as appropriate. Often, even the treatment, interventions, and strategies included in plans of care in annual medical assessments were not included in individuals' IHCPs. On a positive note, even though many were missing, documentation generally was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs.

Overall, the Center regressed with regard to its scores for non-Facility consultations. For example, based on the Monitoring Team's review of IPNs related to consultations for other indicators in this outcome, numerous instances were identified in which PCPs did not indicate agreement or disagreement with consultations recommendations. As a result, the related indicator will move back to active oversight. In addition, PCP IPNs should follow State Office policy, including making recommendations regarding the need for IDTs to meet to discuss consultations.

The Center should focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Over the past two reviews and this one, the Dental Department generally provided individuals reviewed with dental x-rays in accordance with relevant standards. So, the related indicator will move to the category requiring less oversight. It also was good to see that the dentist quickly saw the individual reviewed who required an assessment of a potential dental emergency. However, a number of individuals reviewed had not had needed dental treatment, including, for example, prophylactic care, tooth-brushing instruction, fluoride applications, and development and implementation of treatment plans to address periodontal disease.

The Center should take steps to ensure individuals' adaptive equipment is consistently clean. After the last review, the related indicator was moved to less oversight, but during this review, for approximately 15% of the adaptive equipment observed, a lack of cleanliness was a problem. Failure to correct this problem could result in this indicator moving back to active monitoring. Proper fit also was sometimes still a concern.

Based on observations, there were still numerous instances (58% of 69 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

<table>
<tr><td colspan="2">Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.</td></tr>
<tr><td>Summary: Two indicators met criteria for both individuals, but not yet sustained for any period of time. Criteria were not met for both individuals for the other indicators. Indicators 20-23 require specific content of IDT discussions following the more than three in 30-day criteria. All of the indicators will remain in active</td><td>Individuals:</td></tr>
</table>

monitoring (except for those already moved to the category of requiring less oversight).												
#	Indicator	Overall Score	459	202								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2	1/1	1/1								
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	0/1	0/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	0/1	0/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/2	0/1	0/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	50% 1/2	1/1	0/1								
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).											
26	The PBSP was complete.	N/A	N/A	N/A								
27	The crisis intervention plan was complete.	100%	1/1	1/1								

		2/2									
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/2	0/1	0/1							
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	50% 1/2	1/1	0/1							

Comments:

19. Two of the individuals, Individual #459 and Individual #202, experienced more than three restraints in a rolling 30-day period. Although the documents provided prior to the onsite visit did not include an ISPA regarding repeated restraint for Individual #459, minutes from an ISPA held on 3/22/17 were provided when requested onsite. These were not in Care Tracker format. When the director of behavioral services was asked about these being excluded from the original documents, she explained that Individual #459's information was not always entered in a timely manner. For Individual #202, an ISPA meeting was held within 10 business days of the fourth restraint. Three of the five restraints reviewed at this meeting were not included on the master list of crisis intervention restraints, raising questions about the list's accuracy and whether all occurrences are being reviews as required.

20-23. The minutes from the ISPA for Individual #459 indicated that her IDT discussed biological, medical, and psychosocial variables, contributing environmental conditions, and consequences that may maintain the behaviors that lead to restraint. There were no reviews of her adaptive skills and immediate antecedents. Even when variables resulting in restraint were identified, there were no action plans to address these. It would be advisable for behavioral services staff to complete or update the functional behavior assessment following Individual #202's repeated restraint. His current assessment was completed shortly after his admission and did not include indirect and direct assessments.

24-26. Both Individual #459 and Individual #202 had a PBSP and CIP. PBSPs are reviewed in detail in the Psychology/Behavioral Health sections of this report

27. Although both individuals had complete Crisis Intervention Plans, there were questions about the release criterion for Individual #459. Specifically, her CIP indicated she would be released when she displayed "…10 minutes being still without struggling, kicking, or attempting aggression toward staff." When the director of behavioral health services was asked about this, she explained that the longer duration reduced the number of repeated restraints within one crisis episode. Unless a specific plan is developed to reduce the release criterion, this is a very long time for an individual to remain still and falls outside of the typical criteria of there no longer being imminent danger to the individual or others.

28. Progress reports for Individual #459 consistently indicated that "staff members have been observed implementing the plan as written." There was no data-based review of treatment integrity. Progress reports for Individual #202 did not provide any information regarding treatment integrity.

29. Minutes from the ISPAs for the two individuals indicated that the IDT for Individual #459, but not Individual #202, determined that her PBSP was still appropriate.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: None of the individuals to whom this outcome applied experienced a change of status that would require re-administration of the Reiss scale. These two indicators will remain in active monitoring for possible scoring at the next review.			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A										
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A										
Comments: 2-3. Of the 16 individuals reviewed by both Monitoring Teams, four individuals were not receiving psychiatric services. None of them had change of status that would have required re-administration of the Reiss scale.												

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.												
Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630	
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
11	Activity and/or revisions to treatment were implemented.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	

		9/9									

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%.

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

Summary: Two PBSPs were not updated, which resulted in zero scores for those two individuals. For the remaining, six of seven met criteria for these two indicators. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1

Comments:
23. The psychiatric documentation referenced specific behaviors and psychiatric symptoms that were being tracked by behavioral health. The psychiatrist attempted to correlate the behavioral health target behaviors to the diagnosis. In addition, the functional assessment included information regarding the individual's psychiatric diagnosis and included the effects of said diagnosis on the target behaviors. There were two individuals who did not have current functional assessments or behavioral support plans, Individual #313 and Individual #240. For Individual #333, there was no discussion of the effects of anxiety upon his behavioral presentation.

24. There was documentation of the psychiatrist's review of the PBSP in the psychiatric clinical documentation (one exception was for Individual #333). In addition, in the psychiatry clinical encounters observed during the monitoring visit, the psychiatrist asked questions and made comments regarding the PBSP. Two individuals did not have current PBSPs, Individual #313 and Individual #240.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.

Summary: There was good and regular collaboration between psychiatry and neurology for this review period and the past two reviews, too. Thus, indicators 25 and 26 will be moved to the category of requiring less oversight. Improvements in documentation in both disciplines' notes resulted in 100% score for indicator 27. This indicator will remain in active monitoring given the 0% score at the last	Individuals:

review.											
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 5/5	N/A	1/1	N/A	1/1	N/A	1/1	1/1	N/A	1/1
26	Frequency was at least annual.	100% 4/4	N/A	1/1	N/A	1/1	N/A	N/A	1/1	N/A	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 5/5	N/A	1/1	N/A	1/1	N/A	1/1	1/1	N/A	1/1
Comments: 25-27. These indicators applied to five individuals. Individual #202 had not been at the facility for a year, so it was not possible to determine if consultation occurred annually. The facility has a functioning neuro-psych clinic and there was documentation of collaboration between neurology and psychiatry for those individuals treated with medications for a dual purpose.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Continued attention to the content of the quarterly review documentation is needed. Some improvement was seen within the content, as described in the comments below. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing one to three components; most commonly, a review of the implementation of non-pharmacological interventions recommended by the psychiatrist and approved by the IDT, the psychiatric symptoms that support the psychiatric diagnosis, and basic information (timely height, weight, and vital signs).											

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
Comments: 36. Assessments and prescriber review of assessments were generally occurring in a timely manner. Assessments for Individual #630 were performed in March 2017, but not reviewed by the provider. In addition, in the case of Individual #630, there was a gap in assessments with assessments performed in April 2016, but not again until January 2017.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary:			Individuals:								
#	Indicator	Overall Score									
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?										
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?										
Comments:											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: All four important indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	followed policy.										

Comments:
42. There were two individuals, Individual #313 and Individual #240, who did not have a current PBSP, and as such, were receiving medication in the absence of treatment program.

43. The facility did not utilize PEMA.

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.

Summary: Polypharmacy continued to be well-managed at Denton SSLC. With sustained high performance, indicator 46 might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
45	There is a tapering plan, or rationale for why not.										
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments:
46. These indicators applied to two individuals. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for two individuals selected by the Monitoring Team meeting criteria for polypharmacy. Polypharmacy meeting was observed during the monitoring visit. This was a well-attended meeting with thorough reviews of medication regimens meeting criteria for polypharmacy. This was very good to see.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: Given the absence of good, reliable data, progress could not be determined for all of the individuals. The Monitoring Team scored indicators 7, 8, and 9 based upon the facility's report of progress/lack of progress as well as the ongoing exhibition of problem target behaviors. The indicators in this outcome will remain in active monitoring.

#	Indicator	Overall	Individuals: 333	109	459	240	173	202	313	134	630

		Score									
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/4	0/1	N/A	0/1	0/1	N/A	N/A	0/1	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A
9	Activity and/or revisions to treatment were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

6. For seven of the nine individuals, the facility's reported data suggested progress. However, these data were not reliable, therefore, progress could not be determined with certainty. For two individuals, Individual #313 and Individual #134, the data were unreliable and the reported data suggested worsening performance.

7. For four individuals (Individual #333, Individual #459, Individual #240, Individual #313 [one of his two goals]), the facility's data showed mastery of the established objectives. There was no evidence that the teams had updated or made new objectives.

8. There was no evidence that the IDTs for Individual #313 or Individual #134 had initiated corrective action plans to address their worsening performance.

9. There were no identified actions or revisions for any of the individuals.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.

Summary: Insufficient numbers of staff were shown to be properly trained in the PBSPs. Summaries, however, were now available for float staff for most of the individuals. During review of PBSPs, the Monitoring Team noticed that the facility had not maintained BCBA supervision of PBSP documents as required by the criteria for indicator 18. Specifically, five of the nine (i.e., more than half) did not include BCBA sign-off on PBSPs written by behavioral health services staff who had not yet completed their full certification requirements. Therefore, indicator 18 will be returned to active monitoring. Indicators 16 and 17 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	78%	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1

		7/9									
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. However, due to poor maintenance of performance, this indicator will be moved back into active monitoring.									

Comments:

16. Of the nine individuals, there was evidence that 80% or more of the staff assigned to work with one individual, Individual #173, had been trained. It should be noted that his PBSP had only recently been introduced, so many of those who had been trained, were trained on the strategies put in place at the time of his admission. As indicated by the BCBA, many of these same strategies were included in his PBSP. For the remaining eight individuals, evidence indicated that between 17% (Individual #134) and 71% (Individual #202) of the assigned staff had been trained.

17. There was a PBSP summary for seven of the nine individuals. The exceptions were Individual #459 and Individual #202. It was noted that only staff with level-one training were to work with these individuals.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.

Summary: It was good to see that behavioral health services progress notes now commented upon the progress of the individual. Graphic summaries, however, continued to be done in a way that was not useful for making treatment decisions. Peer reviews were occurring, some more frequently than the minimum requirements, some less than the minimum requirements. These five indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
19	The individual's progress note comments on the progress of the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	67% 2/3	N/A	0/1	N/A	1/1	N/A	N/A	N/A	N/A	1/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	86% 6/7	N/A	1/1	1/1	1/1	1/1	1/1	N/A	0/1	1/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external	0%									

	peer review occurred at least five times, for a total of at least five different individuals, in the past six months.		

Comments:

19. The monthly behavioral health progress notes for each of the nine individuals included comments regarding their progress on their PBSPs.

20. None of the individuals had graphs that were considered useful for making data-based decisions. In several cases (Individual #333, Individual #109, Individual #459, Individual #240, Individual #173, Individual #202), there were too many data paths on one graph. For others, phase change lines were not consistently included to depict significant events (e.g., hospitalization, medication changes, change in data collection method).

21. During the onsite visit, three clinical review meetings were observed. Two individuals (Individual #240, Individual #630) were reviewed in psychiatric clinic. In each case, graphs depicting progress on the PBSP were presented to the psychiatrist. Staff are advised to either present graphs to all IDT members present or to verbally review the individual's performance. At Individual #109's ISP meeting, discussion was held regarding his daily showering, but no data were reviewed.

22. Minutes from peer review meetings indicated that seven of the nine individuals had been reviewed over the previous six months. For six of these individuals, there was evidence that recommendations had been addressed. The exception was Individual #134 for whom a distinction was to be made between functional self-injury and self-injury indicative of her psychiatric symptoms. There was no evidence that this distinction had been addressed.

23. As reported by the director of behavioral health services, the PBSC meets weekly. Internal peer review met 14 times between 11/1/16 and 4/30/17, but did not meet the identified criterion of three times each month. External peer review meetings occurred 48 times during this same six-month period, exceeding the identified criterion.

Outcome 8 – Data are collected correctly and reliably.

Summary: These five indicators will remain in active monitoring. In previous reviews, indicators 26 and 27 met criteria, but perhaps due to changes in the electronic data system, criteria were not met for this review. Ensuring PBSP reliability and implementation integrity needed more attention, too.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	measures of data collection timeliness, IOA, and treatment integrity.	0/9									
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26-27. Because the facility had only recently addressed timely documentation of data, the data collection systems did not adequately measure individuals' target or replacement behaviors. Additional concerns were raised for Individual #109, whose property destruction was measured in one-hour intervals and for Individual #134, whose self-injury was recorded only if she caused permanent injury as determined by nursing staff.

28-29. As explained by the director of behavioral health services, inter-observer agreement should be assessed each month. The expected level of agreement is 80%. There are no identified measures or levels established to assess data timeliness or treatment integrity. Expected timeliness of data recording had just recently been changed from eight hours to two hours.

30. Progress reports for none of the nine individuals reflected adequate assessment of data timeliness, inter-observer agreement, or treatment integrity.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	necessary action.	0/18									
	Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #313 – respiratory compromise, and cardiac disease; Individual #134 – respiratory compromise, and GI problems; Individual #92 – respiratory compromise, and GI problems; Individual #186 – GI problems, and cardiac disease; Individual #269 – weight, and falls; Individual #255 – diabetes, and weight; Individual #433 – GI problems, and osteoporosis; Individual #507 – GI problems, and weight; and Individual #349 – seizures, and falls). None of the goals/objectives reviewed were clinically relevant, achievable, and measurable. c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.										

Outcome 4 – Individuals receive preventative care.											
Summary: Seven of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	86% 6/7	1/1	1/1	0/1	N/A	1/1	1/1	N/A	1/1	1/1
	iii. Breast cancer screening	100% 5/5	N/A	1/1	N/A	1/1	1/1	1/1	N/A	1/1	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
	vii. Cervical cancer screening	100% 5/5	N/A	1/1	N/A	1/1	1/1	1/1	N/A	1/1	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. Overall, the individuals reviewed generally received timely preventive care, which was good to see. The following problems were noted:

- Individual #92's last colonoscopy occurred on 6/12/06.
- For Individual #269, the record needs clarification, because a Tdap (Adacel) administration date of 10/3/10 was included in one part of the record, but the immunization record stated Td (i.e., vaccine without the pertussis component) and not Tdap (i.e., vaccine with the pertussis component).

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

Summary: The Monitoring Team will continue to review this indicator.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. Individual #92 did not have a condition that justified the DNR Order consistent with the State Office Guidelines. More specifically, the reason given on the 12/5/13 document was: "chronic lung disease, hypothyroidism, osteoporosis, and severe spastic quadriplegia." The out-of-hospital DNR listed: "senile degeneration of the brain" as the reason.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

Summary: The Centers scores for these indicators have varied, and during this review, regression was noted for a number of them. It is important that providers conduct and document thorough assessments of acute medical issues. In addition, when individuals are transferred to the hospital, the PCP or a nurse needs to communicate necessary clinical information with hospital staff. It was positive that	Individuals:

for most acute issues, providers conducted necessary follow-up. Except for Indicator e, these indicators will remain in active monitoring.											
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	71% 5/7	N/A	1/1	1/2	N/A	1/2	N/A	N/A	2/2	N/A
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	80% 4/5		0/1	2/2		N/A			2/2	
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	40% 4/10	0/1	1/2	1/2	0/1	1/1	N/A	1/1	0/1	0/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	20% 1/5	0/1	0/1	0/1	N/A	N/A		1/1	N/A	0/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	10% 1/10	0/1	0/2	0/2	1/1	0/1		0/1	0/1	0/1
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	83% 5/6	1/1	1/1	1/2	1/1	N/A		N/A	1/1	N/A
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	89% 8/9	1/1	2/2	2/2	1/1	1/1		N/A	1/1	0/1

Comments: a. and b. For four of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed seven acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #134 (wheezing on 2/20/17), Individual #92 (cellulitis of ear on 12/3/16, and finger fracture on 2/8/17), Individual #269 (rash on buttocks on 11/29/16, and self-inflicted injuries on 2/24/17), and Individual #507 (emesis on 12/6/16, and clogged GJ-tube on 12/7/16).

The acute illnesses for which documentation was not present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #134 (wheezing on 2/20/17), and Individual #269 (rash on buttocks on 11/29/16). For these acute illnesses treated at the Facility, medical providers did not cite the source of the information (e.g., nursing, activities/workshop staff, PT, OT, etc.).

The PCP did not complete a follow-up IPN with regard to Individual #134's wheezing on 2/20/17.

c. For eight of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #313 (hospitalization for acute respiratory distress on 3/17/17), Individual #134 (hospitalization for sepsis and aspiration pneumonia on 11/23/16, and ED visit for clavicle fracture on 12/24/16), Individual #92 (hospitalization for agonal breathing on 12/4/16, and hospitalization for malfunctioning GJ-tube on 1/14/17), Individual #186 (hospitalization for pneumonia on 12/15/16), Individual #269 (ED for scalp laceration on 2/28/17), Individual #433 (hospitalization for respiratory distress on 3/20/17), Individual #507 (hospitalization for projectile vomiting on 11/18/16), and Individual #349 (ED visit for fall with laceration on 2/3/17).

For the following acute events, PCP IPNs were completed or completed on the next business day: Individual #134 (ED visit for clavicle fracture on 12/24/16), Individual #92 (hospitalization for malfunctioning GJ-tube on 1/14/17), Individual #269 (ED for scalp laceration on 2/28/17), and Individual #433 (hospitalization for respiratory distress on 3/20/17).

d. Five of the acute illnesses reviewed occurred after hours, on a weekend/holiday, or on an emergent basis, so this indicator was not applicable. For Individual #433's hospitalization for respiratory distress on 3/20/17, the provider conducted a quality assessment and documented it in an IPN.

f. The individual that was transferred to the hospital for whom documentation was submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff was Individual #186 (hospitalization on 12/15/16).

g. In several cases, IDT developed a number of action steps to address follow-up medical and healthcare supports to reduce risks and promote early recognition. For Individual #186's hospitalization for pneumonia on 12/15/16, no ISPA was found.

h. It was good to see that for most of the individuals reviewed, upon their return to the Center, there was evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness. The exception was for Individual #349 (ED visit for fall with laceration on 2/3/17) for which no follow-up IPN(s) was found.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Overall, the Center regressed with regard to its scores for this outcome. For example, based on the Monitoring Team's review of IPNs related to consultations for other indicators in this outcome, numerous instances were identified in which PCPs did not indicate agreement or disagreement with recommendations. As a result, Indicator a will move back to active oversight. In addition, PCP IPNs should follow State Office policy, including making recommendations regarding the need for IDTs to meet to discuss consultations.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight. Given that in numerous instances, PCPs did not indicate agreement or disagreement with consultants' recommendations, Indicator a will move back to active oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.	75% 12/16	1/1	0/2	2/2	2/2	1/2	2/2	2/2	0/1	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	38% 6/16	1/1	0/2	2/2	0/2	0/2	2/2	0/2	0/1	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	60% 9/15	1/1	0/2	1/2	1/1	1/2	2/2	1/2	0/1	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/2	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #313 for ophthalmology on 1/17/17; Individual #134 for hematology on 11/15/16, and allergist on 12/12/16; Individual #92 for neurology on 12/28/16, and orthopedics on 3/7/17; Individual #186 for hematology on 12/21/16, and urology on 2/1/17; Individual #269 for podiatry on 1/13/17, and podiatry on 4/19/17; Individual #255 for neurology on 3/29/17, and ophthalmology on 4/11/17; Individual #433 for podiatry on 2/8/17, and ophthalmology on 2/22/17; Individual #507 for ophthalmology on 1/27/17; and Individual #349 for neurology on 12/14/16, and urology on 1/17/17.

a. In reviewing IPNs for other indicators, numerous instances were identified in which PCPs did not indicate agreement or disagreement with the recommendations. These included Individual #134 for hematology on 11/15/16, and allergist on 12/12/16; Individual #186 for hematology on 12/21/16, and urology on 2/1/17; Individual #269 for podiatry on 1/13/17, and podiatry on 4/19/17; Individual

#507 for ophthalmology on 1/27/17; and Individual #349 for urology on 1/17/17.

b. PCPs did not review the following consultations timely: Individual #134 for hematology on 11/15/16, and allergist on 12/12/16; Individual #269 for podiatry on 1/13/17; and Individual #507 for ophthalmology on 1/27/17.

c. Less than half of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. Those that did were for Individual #313 for ophthalmology on 1/17/17; Individual #92 for neurology on 12/28/16, and orthopedics on 3/7/17; Individual #255 for neurology on 3/29/17, and ophthalmology on 4/11/17; and Individual #349 for neurology on 12/14/16.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the following exceptions: Individual #134 for hematology on 11/15/16, and allergist on 12/12/16; Individual #92 for orthopedics on 3/7/17; Individual #269 for podiatry on 4/19/17; Individual #433 for ophthalmology on 2/22/17; and Individual #507 for ophthalmology on 1/27/17.

e. Individual #134's allergist recommended elemental amino acid-based formula, continuation of the current allergy serum mix, and avoidance of dust mite, cockroach, and animal dander. It would have been beneficial to involve the IDT in discussion of these recommendations. Similarly, due to the possible need for pre-treatment sedation, Individual #186's IDT should have discussed Individual #186's urology consultation on 2/1/17.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.

Summary: Work is needed to ensure that PCPs address individuals' chronic or at-risk conditions by completing medical assessments, tests, and evaluations consistent with current standards of care, and identifying the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	44% 8/18	2/2	0/2	0/2	2/2	0/2	1/2	1/2	1/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #313 – respiratory compromise, and cardiac disease; Individual #134 – respiratory compromise, and GI problems; Individual #92 – respiratory compromise, and GI problems; Individual #186 – GI problems, and cardiac disease; Individual #269 – weight, and falls; Individual #255 – diabetes, and weight; Individual #433 – GI problems, and osteoporosis; Individual #507 – GI problems, and weight; and Individual #349 – seizures, and falls).

a. It was positive that for the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as

appropriate: Individual #313 – respiratory compromise, and cardiac disease; Individual #186 – GI problems, and cardiac disease; Individual #255 – diabetes; Individual #433 – osteoporosis; Individual #507 – weight; and Individual #349 – seizures. The following provides examples of concerns noted:

- Over the prior decade, Individual #92 was hospitalized for pneumonia numerous times. He had a history of reactive airway disease, intermittent hypoxia due to chronic bronchitis/chronic obstructive pulmonary disease (COPD), as well as aspiration pneumonia and community acquired pneumonia. Most recently, between 4/28/17 to 5/1/17, he was hospitalized for pneumonia. At Denton SSLC, respiratory therapists monitor him. His PCP referred him to a pulmonary medicine consultant. The PCP took steps that included moving Individual #92 away from the direct airflow of air conditioning; stopping a scopolamine patch, because it was associated with increased difficulty expectorating and clearing thickened secretions; and consideration of discussions with the hospitalist focusing on extending hospitalizations with intravenous (IV) antibiotic use should another pneumonia occur. Staff provided him with suction tooth brushing, but not according to the schedule the Dental Department indicated was needed. Monitoring of suction tooth brushing was done, however, evidence focused on the presence and cleanliness of equipment, but not on the quality of the actual technique. In addition, Individual #92 exhibits challenging behaviors, including pica as well as taking food that is not his, which is problematic given that he is fed by gastrostomy-jejunostomy (GJ) tube. The potential impact of pica was noted in the RN Case Manager documentation, which showed a possible correlation between pica events and hospitalizations. As is discussed further below, Individual #92 did not have a PBSP. The PCP appeared to be treating Individual #92 without the collaboration/help of other departments critical to his care, specifically the Behavioral Health Services and the Dental Departments. Although the PCP responded in a clinically appropriate manner to numerous acute respiratory events, the PCP needs to work with other departments to complete evaluations and identify treatments to ensure a rigorous plan of care.

- Individual #92 had dysphagia, gastroparesis, gastroesophageal reflux disease (GERD), a hiatal hernia, and severe longstanding rumination. Concerns related to weight loss were documented as far back as 2006, and were associated with his rumination. In 2006, the PCP obtained a surgical consult to consider the option of a fundoplication, but no information was provided as to the outcome. The PCP did not know if a fundoplication had been performed or not. A percutaneous endoscopic gastrostomy (PEG) tube was placed later in 2006, followed by a GJ tube. Since that time, Individual #92 had numerous ED visits to replace the GJ tube due to malfunctioning. In July 2016, he had hematemesis. In December 2016, he had emesis due to his chewing on a towel and "sticking it too far down" his throat. The PNMT followed him for positioning, with a recommendation in January 2017 for head-of-bed elevation (HOBE) at 30 degrees and a z-flo pillow when in a recliner. He was prescribed Reglan for gastroparesis, and Nexium for GERD/gastritis. Individual #92 has had five episodes of pica/eating food by mouth in contradiction to his diet in the past year, three of them (i.e., popcorn, paper, and plastic) since March 2017. Additionally, in March 2017, he was found crawling on the floor at night moving towards a door. His long-standing concern of weight loss continued, and as recently as March 2017, the nutritionist increased the number of hours of formula feeding. It was unclear whether or not the IDT had assigned the correct level of supervision, and/or developed a reasonable plan to address his pica and/or eating food by mouth in contradiction to his diet order, placing him at high risk. Despite the ongoing weight loss due in part to severe rumination, the Integrated Behavioral Health Assessment stated Individual #92 "does not currently have a formal Positive Behavior Support Plan and the Inter Disciplinary Team continues to believe he does not require one. He does not display any problematic behavior." Considering Individual #92's challenges with gaining and maintaining weight and his ongoing rumination as well as pica/eating food by mouth in contradiction to his diet, this conclusion was concerning. The lack

of the PCP's knowledge of Individual #92's prior medical/surgical history also needed resolution.

- Individual #134 had a history of scarring of both lung bases due to repeated aspiration pneumonia, as well as diagnoses of allergic rhinitis, dysphagia, and a congenital abnormality of the epiglottis resulting in physiological incompetence. Medications prescribed included Ipratropium and Albuterol nebulizer treatments, as well as medications for her allergies (Singulair, Claritin, Budesonide nebulizer treatment, and Astelin nose spray). In 2011, and more recently in 2016, she underwent allergy testing. Due to the findings, air duct cleaning occurred in her home. She used a continuous positive airway pressure (CPAP) machine with oxygen supplementation at bedtime. She also received suction tooth brushing. On 2/6/17, a pulmonary medicine specialist was consulted, and determined she had allergic rhinitis and probably asthma. No additional medication was recommended.

  In the past, Individual #134 was reviewed for consideration of a tracheal diversion, but this was not pursued, because she would lose her ability to vocalize. She currently received allergy shots, after a series of tests demonstrated she had several significant environmental and food allergies. Any positive outcome from these allergy shots remained to be determined. Other than cleaning the ducts, it was not clear her IDT took any additional steps to reduce allergies in her home (e.g., hypoallergenic covers for pillows, etc.)

  In recent months, due to results of her allergy testing showing significant food allergies, Individual #134's feeding formula was changed. The allergist recommended an elemental amino acid-based formula. This required an increase in volume administered to meet her caloric nutritional needs. Starting on 1/20/17 and again on 2/1/17, the rate of administration was increased. Since that time, Individual #134 had several episodes of wheezing, and she was treated with Prednisone for one such episode on 2/20/17. Based on the submitted documentation, it did not appear the PCP considered whether the increased formula rate was associated with reflux and subsequent reactive airway disease. Residuals appeared to be checked at the start of the continuous nighttime feeding, but not before the daytime bolus feedings.

- Individual #134 had a history of a B ring of the distal esophagus, a small hiatal hernia, reflux esophagitis, gastroparesis, and gastritis/steroid gastropathy. In the past, she received periodic esophageal dilatations for stricture formation, but the current GI specialists no longer recommended this for her. In 2013, she received a PEG tube. On 1/17/17, a PNMT evaluation revealed that she was not positioned correctly for her tube feedings and recommended monitoring her position at night while feeding occurred. The submitted documentation did not include evidence of the monitoring and/or monitoring findings. As discussed above, her allergist recommended a change in formula feeding, and as a result the rate of administration had to be increased. The impact on gastroparesis and reflux was not further discussed in the submitted documentation, despite several bouts of wheezing subsequent to the increase in rate. On 3/21/17, the dietitian found that the formula was not being administered as ordered, which complicated the situation. The submitted documentation did not include any updated information regarding the severity of Individual #134's gastroparesis or severity of her reflux. She was noted to have a significant behavioral component that affected many areas of her life, including gastrointestinal health. She repeatedly bent over, which would increase her abdominal pressure. This in turn would exacerbate her GERD. No behavioral or psychiatric plan was submitted that addressed this constant motion (e.g., the submitted documents did not indicate whether akathisia or hypomania had been ruled out). Submitted documents did not address active treatment options to reduce this constant motion. In December 2016,

despite the use of an abdominal binder, her Mickey button was displaced. Again, the PCP needs to work with other departments to complete evaluations and identify treatments to ensure a rigorous plan of care.

- Individual #269's IDT had not completed the needed assessments, analyzed the etiology(ies) of her falls, and/or developed a plan to address the findings. In 2016, Individual #269 fell seven times. Most falls were to her buttocks. However, on 11/23/16, she fell when she appeared to be excited and tripped. From 1/1/17 to 5/1/17, she fell 10 times. One fall required an ED visit for a laceration requiring staples. One fall appeared to be associated with a balance issue when she was attempting to stand up from her chair after dinner, but post prandial hypotension was not assessed. On 3/15/17, she jumped off a curb and fell, which needed to be explored for components of impulsiveness or accuracy of depth perception. She tripped and fell three times, suggesting a need to review impulsiveness, visual fields, coordination/chorea, etc. One or more falls were associated with peer-to-peer aggression, for which residential services, behavioral health services, and psychiatry needed to conduct additional assessment. The most recent IRRF indicated that she was impulsive and had behavioral episodes. The only changes at that time were to ensure she wore nonskid socks, encourage her to walk more slowly, and to pay attention to surroundings. The IDT developed no detailed action steps to "encourage" her to walk slowly and to pay attention to her surroundings. As she had profound hearing loss, visual attention to her surroundings was of paramount importance. There was no information as to whether the local deaf society was contacted to assist in providing training to her and her staff in promoting safe ambulation. There was no submitted documentation to indicate a neurological component to her tripping and falling had been ruled out.

- Individual #507 had a history of erosive gastritis. In 2009, a modified barium swallow study (MBSS) did not indicate evidence of aspiration or penetration with thin liquids. In April 2010, due to ongoing anorexia, a G-tube was placed. A proton pump inhibitor (PPI) was ordered, and the bisphosphonate was discontinued. In 2011, a GJ tube was placed. More recently, in February 2016, she was hospitalized for cholecystitis and had a laparoscopic cholecystectomy. In November 2016, she was hospitalized for vomiting. An esophagogastroduodenoscopy (EGD) was done and a GJ tube was placed. Bolus feedings were ordered at the time of discharge. The Dietary Department at Denton SSLC noted this and had the feeding changed to a continuous feeding. The OT conducted a HOBE evaluation. The HOBE was increased from 10 to 20 degrees and Individual #507 was to remain upright for two hours after meals. She continued vomiting. An abdominal binder was discontinued once a Mickey button was placed. The PNMT also found that staff had not been trained in positioning during check and change, as it was observed she was positioned flat during personal care. A 1/19/17 dietary note indicated she was to have nothing by mouth (NPO). She had been offered a snack, but had either consistently refused or vomited the snack.

  Overall, any prior medical evaluations completed were difficult to find in documents submitted. Descriptions of such evaluations and a summary of results should be carried forward in the AMAs as part of the individual's past history. There was no information as to whether any study for gastric residual/gastroparesis had been completed, or whether there was any correlation between the vomiting and any non-GI conditions that might contribute to vomiting (e.g., urinary tract infections, cyclic vomiting, migraine headaches, etc.) From the current 180-day orders printed on 5/30/17, there was an order for NPO except for medications, sips of water, and Jell-O. No order was found for J-tube feeding. From a review of the QDRRs, there was no pharmacy review as to whether the medications were causing her to have anorexia or to vomit, the relationship of medication administration and vomiting, and whether or not the frequency of vomiting caused a sub-therapeutic response

	from medications recently administered before the vomiting events. The anticholinergic burden was discussed in the QDRR, with the side effect of dry mouth, but no action step was recommended to consider whether her medication affected taste. Individual #507 was also noted to place her hand in her mouth, which caused gagging and vomiting, suggesting GERD or pleasure/relief from the gagging. The possibility of rumination that ended in vomiting was not discussed in submitted documents. The AMA did not discuss the role of Behavioral Health Services staff in assessing and developing strategies to reduce the self-induced gagging, nor did it discuss the role of boredom and lack of activities in association with her self-gagging. Although the PCP was in favor of offering her meals, this was eventually discontinued with NPO status due to her refusal of meals by mouth. However, as this will lead to decreased strength in the pharyngeal muscles needed to swallow safely, the IDT should review it on an ongoing basis. Again, the PCP needs to work with other departments to complete evaluations and identify treatments to ensure a rigorous plan of care.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, documentation often was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	78% 7/9	0/1	1/1	2/2	1/1	2/2	N/A	1/1	0/1	N/A
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed often were implemented.											

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	0/1	N/A	0/1	0/1	0/1	N/A	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including	0%	0/1	0/1		0/1	0/1	0/1		0/1	

	timeframes for completion;	0/6									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6	0/1	0/1		0/1	0/1	0/1		0/1	
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6	0/1	0/1		0/1	0/1	0/1		0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1	0/1		0/1	0/1	0/1		0/1	

Comments: a. and b. Individual #92 was edentulous, and was part of the outcome group, so a limited review was conducted. Individual #433, and Individual #349 also were edentulous, but were part of the core group, so full reviews were conducted for them. The Monitoring Team reviewed six individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with summary data and analysis of the data were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individuals have no diagnosed or untreated dental caries.	83% 5/6	1/1	0/1	N/A	1/1	1/1	1/1	N/A	1/1	N/A
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	N/A									
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	67% 4/6	0/1	0/1		1/1	1/1	1/1		1/1	
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: a. Individual #92, Individual #433, and Individual #349 were edentulous. As noted above, Individual #134 did not have an up-to-date dental exam. The previous exam stated caries: "Y/N."

b. Three individuals reviewed were edentulous, and the remaining six individuals had periodontal disease. Individual #313's periodontal disease worsened from Type II to III to Type III. Individual #134's periodontal disease worsened from Type III to Type IV. Three of the remaining individuals had Type III periodontal disease, and one had Type II periodontal disease.

c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: On a positive note, given that over the last two review periods and during this review, individuals had dental x-rays in accordance with applicable standards (Round 10 – 100%, Round 11 – 100%, and Round 12 - 83%), Indicator c will move to the category requiring less oversight. However, a number of individuals reviewed had not had needed dental treatment, including, for example, prophylactic care, tooth-brushing instruction, fluoride applications, and development and implementation of treatment plans to address periodontal disease. These remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	67% 4/6	1/1	0/1	N/A	1/1	0/1	1/1	N/A	1/1	N/A
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	50% 3/6	0/1	1/1		0/1	1/1	1/1		0/1	
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	83% 5/6	1/1	0/1		1/1	1/1	1/1		1/1	
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	50% 3/6	1/1	0/1		0/1	1/1	1/1		0/1	
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	33% 2/6	0/1	0/1		1/1	1/1	0/1		0/1	
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 3/3	N/A	N/A		1/1	N/A	1/1		1/1	
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	50% 1/2	1/1	N/A		0/1	N/A	N/A		N/A	

Comments: a. through f. Individual #92, Individual #433, and Individual #349 were edentulous. A number of individuals reviewed had not had needed dental treatment.

g. For Individual #186, from the documentation provided, it appeared that the dentist obtained verbal and written consent for extraction of a different tooth than the one that was extracted. More specifically, consent was for extraction of tooth #25, but the dentist extracted tooth #24. Consent was correctly obtained for the extraction of tooth #5.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: It was good to see that the dentist quickly saw the individual reviewed who required an assessment of a potential dental emergency. If the Dental Department sustains this level of performance, at the time of the next review, Indicator a might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A						N/A			
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A						N/A			
Comments: a. through c. Based on IPNs the Center provided, on 4/7/17, Individual #255 saw the dentist within approximately a half an hour of the nurse requesting an emergency appointment. The exam was negative, so the individual required no dental treatment or pain management.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: The Center needs to focus on improving the planning for and implementation and review of suction tooth brushing. The Monitoring Team will continue to review all of these indicators.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	50% 2/4	N/A	1/1	N/R	1/1	N/A	N/A	0/1	0/1	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/4		0/1		0/1			0/1	0/1	
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/4		0/1		0/1			0/1	0/1	
d.	At least monthly, the individual's ISP monthly review includes specific	0%		0/1		0/1			0/1	0/1	

	data reflective of the measurable goal/objective related to suction tooth brushing.	0/4									

Comments: Individual #92 was edentulous, and was part of the outcome group, so a limited review was conducted.

a. through b. For Individual #134 and Individual #186, IDTs included measurable action steps related to suction tooth brushing in their ISPs/IHCPs, which was good to see. However, documentation showed that staff did not implement suction tooth brushing with these individuals twice a day as required. For the remaining two individuals, IDT had not included measurable action steps. However, for most days for Individual #433, staff did not provide and/or document the provision of any suction tooth brushing. For Individual #507, it did not appear staff ever began implementing suction tooth brushing.

c. The Center did not submit evidence to show Dental Department staff monitored the quality of suction tooth brushing. The monitoring that was completed was of equipment, but it appeared staff completed some or all of this monitoring by telephone.

d. QIDPs had not included data and/or analysis of data related to suction tooth brushing in the integrated monthly reviews for these individuals.

Outcome 9 – Individuals who need them have dentures.

Summary: The Center showed continuing improvement with regard to the dentist's assessment of the need for dentures for individuals with missing teeth. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									

Comments: None.

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.

Summary: Based on interview with the Chief Nurse Executive (CNE), nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be

Individuals:

corrected. These indicators will remain in active oversight.											
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. Based on interview with the Chief Nurse Executive (CNE), nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected. The Monitoring Team discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist in the documentation provided. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should work with State Office to correct this issue.										

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	measure the efficacy of interventions.	0/18									
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #313 – dental, and other: bleeding due to Warfarin; Individual #134 – constipation/bowel obstruction, and falls; Individual #92 – skin integrity, and UTIs; Individual #186 – dental, and constipation/bowel obstruction; Individual #269 – falls, and dental; Individual #255 – weight, and GI problems; Individual #433 – GI problems, and weight; Individual #507 – constipation/bowel obstruction, and dental; and Individual #349 – skin integrity, and falls). None of the goals/objectives were clinically relevant, achievable, and measurable

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: Given that over the last four review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/14	0/2	0/2	0/1	0/2	0/1	0/1	0/2	0/2	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: As noted above, the Monitoring Team reviewed a total of 18 specific risk areas for nine individuals, and as available, the IHCPs to address them.

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

The following provide a few examples of concerns noted:

- Although the documentation indicated that Individual #313 and Individual #186's behaviors were barriers to their dental assessments and care, Behavioral Health Services staff did not appear to be involved in developing interventions to improve access to dental care. For example, Individual #186 had two teeth extracted due to decay, but still the IDT did not require BHS staff's involvement. Similarly, Individual #313 required IV sedation for dental work, but the IDT provided no alternative interventions.
- Based on documentation the Center submitted, in the previous six months, Individual #134 had 11 instances of constipation requiring suppositories, which was an increase from two the previous ISP year. However, no documentation was found of IDT discussion to address the issue, and it was unclear if the PCP was aware of the number of suppositories required.
- On 11/4/16, Individual #134's IDT met for her ISP meeting. On 12/24/16, she fell while coming out of the shower and fractured her clavicle. On 12/22/15, she previously had fractured her right clavicle. According to ISPA documentation, on 12/27/16, her IDT met and recommended changes to her PNMP, including wearing socks and shoes at all times while transferring and walking, staff holding her gait belt, and adding a sling to her left shoulder (due to the fractured left clavicle). The IDT also agreed Habilitation Therapy staff would continue to assess her for additional revisions to the PNMP, and in-service direct support professionals on the modified PNMP. However, the IDT did not update her IHCP to include interventions to prevent falls.

  On 1/31/17, the team met again in response to two additional falls on 1/27/17, and 1/28/17. At this time, the IDT recommended that only staff who were trained through an in-service would be assigned to Individual #134 (although the ISPA indicated that she was with regular staff at the time of these falls) and direct support professionals would complete in-service training on walking instructions and her level of supervision. However, the IDT did not complete and/or document in the ISPA an analysis of the underlying cause(s) of her falls to support the recommendations. Given that she had just sustained a fracture four weeks earlier, this was very concerning. The IDT did not update the IHCP addressing this risk area.

  Then, the ISPA, dated 2/27/17, noted that on 2/23/17, she fell and hit her head while trying to pick up paper, and that the OT/PT was to train her to use a reacher tool. At this time, the IDT made no modifications to her IHCP.

  No ISPAs were found addressing additional falls on 2/27/17, or 3/26/17. An ISPA, dated 4/3/17, noted that on 4/1/17, she fell again from tripping on a shoe lace and fractured her right patella. At this time, the IDT implemented a Change of Status IHCP that merely indicated that she was not to have shoes with shoe strings or velcro. Unfortunately, the documentation still did not reflect that the IDT conducted an analysis of her numerous falls to determine the underlying cause(s)/etiology(ies). As a result, the IDT continued to address her falls and fractures reactively as opposed to proactively.
- On 3/1/17, Individual #269's IDT held an ISPA meeting to discuss a fall she sustained on 2/28/17, during which she tripped

over a privacy screen while trying to hit a peer. This resulted in a trip to the ED and five staples to her head. However, it appeared the IDT was diverted and focused on her stealing food, even though the ISPA indicated this was not a factor in her significant fall, and added interventions to her plan related to this issue. With regard to the falls, the ISPA concluded that: "she has had 10 falls since December 2016." Despite a significant injury, no analysis of the underlying cause(s) of her fall or past falls was included in the ISPA. The IDT only recommended that the nurse give medications to Individual #269 in a vacant room so that a privacy screen would not be needed. Since that event, no other ISPAs were found addressing subsequent falls.

- From a review of the ISPAs provided, the IDT did not address the impact of Individual #507's frequent emesis on her oral health and teeth. It was not clear from the documentation provided if the dentist was aware of how often this individual vomited, and/or made recommendations for her oral care after these episodes. In addition, there was no mention if her tooth brushing caused any gagging or precursors to her vomiting episodes.
- Individual #349 was not only at risk for falls, but actually fell 12 times since December 2016 (if the data provided to the Monitoring Team was accurate). In addition, two of these falls resulted in staples and sutures to his head. One of these falls occurred in the month prior to the ISP meeting. However, based on the ISPA, dated 2/6/17, regarding the most recent fall with a serious injury, the IDT still did not include any nursing interventions or other preventative interventions in the IHCP for falls. Overall, the IDT showed a lack of urgency in addressing Individual #349's falls.

Outcome 6 – Individuals receive medications prescribed in a safe manner.

Summary: For the two previous reviews, as well as this review, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; and 2) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.

Individuals:

#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
d.	In order to ensure nurses administer medications safely:										

	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/A									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	50% 4/8	0/1	0/1	0/1	1/1	0/1	1/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #313, Individual #134, Individual #92, Individual #186, Individual #269, Individual #255, Individual #507, and Individual #349.

c. It was positive that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration.

d. An intervention for ongoing lung sound assessments was not included in Individual #92's IHCP. Although the RN administering medications attempted to listen to his lung sounds before/after medication administration, she did not place the stethoscope in the correct positions in order to hear them. This RN, who was working in the Infirmary, was taken off the floor for retraining.

f. At times, medication nurses did not use the individuals' PNMPs to check the position of the individuals prior to medication administration. Other problems noted included nurses not administering medications at eye level, and not locking an individual's wheelchair.

g. For the individuals observed, nursing staff followed infection control practices, which was good to see.

l. and m. Although the Monitoring Team did not assess these indicators, the Monitoring Team identified a concern that needs attention. For Individual #313, on 12/21/16, a variance was discovered and the form indicated that on 11/30/16, a nine-day supply of valproate sodium 250 milligrams/milliliters (mg/ml) 480 ml syrup was filled, but no refill request was made until 12/21/16. The IRRF noted that Individual #313 had not had a seizure for the past three years, but then had one on 12/31/16. The Center provided no seizure report, and there was no indication from the documentation provided that the IDT considered that this medication variance could have been a possible factor in precipitating the seizure. On 12/31/16, a nursing IPN noted the seizure-like activity. However, the nurse did not complete or document a comprehensive assessment or provide any indication of whether or not the PCP was notified of this event. No IPN from the PCP was found addressing the seizure or the variance. In addition, there was a variance form indicating that his eight-day supply of lactulose 10 grams (g)/15 ml oral syrup 480 ml was last filled on 12/13/16, and no request was made to refill it until 1/10/17. The nursing annual indicated he needed a suppository for constipation, but did not give a date of the episode.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. In addition, work is still needed with regard to IDTs referring individuals to the PNMT, when needed, or the PNMT making self-referrals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	313	134	92	186	269	255	433	507	349

		Score									
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	N/A	N/A	0/1	0/1	0/2	0/2	0/1	N/A
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/8	0/1			0/1	0/1	0/2	0/2	0/1	
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/8	0/1			0/1	0/1	0/2	0/2	0/1	
	iv. Individual has made progress on his/her goal/objective; and	0% 0/8	0/1			0/1	0/1	0/2	0/2	0/1	
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1			0/1	0/1	0/2	0/2	0/1	
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	45% 5/11	0/1	1/2	1/2	1/1	0/1	N/A	1/1	1/1	0/2
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/10	0/1	0/2	0/2	0/1	0/1		N/A	0/1	0/2
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/10	0/1	0/2	0/2	0/1	0/1			0/1	0/2
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/10	0/1	0/2	0/2	0/1	0/1			0/1	0/2
	v. Individual has made progress on his/her goal/objective; and	0% 0/10	0/1	0/2	0/2	0/1	0/1			0/1	0/2
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/10	0/1	0/2	0/2	0/1	0/1			0/1	0/2

Comments: a.i. and a.ii. The Monitoring Team reviewed seven goals/objectives related to PNM issues that six individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #313; skin integrity for Individual #186; choking for Individual #269; falls, and constipation/bowel obstruction for Individual #255; falls for Individual #433; and aspiration for Individual #507. None of the IHCPs included clinically relevant, achievable, and/or measurable goals/objectives.

b.i. The Monitoring Team reviewed 11 areas of need for eight individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: aspiration for Individual #313; aspiration, and weight for Individual #134; weight, and aspiration for Individual #92; aspiration for Individual #186; falls for Individual #269; aspiration for Individual #433; GI problems for Individual #507; and aspiration, and falls for Individual #349.

These individuals should have been referred or referred sooner to the PNMT:

- Since January 2017, Individual #313 had a declining ability to swallow safely. In January 2017, a dysphagia assessment recommended a ground texture diet with thin liquids. By March 2017, it was recommended he receive nothing by mouth (NPO), followed by a recommendation for a pureed texture diet with nectar-thick liquids. In May 2017, he had another modified barium swallow study (MBSS) that recommended NPO again. The PNMT held only one meeting with the IDT, and this did not occur until 5/3/17. No PNMT minutes or notes were found showing discussion of Individual #313's laryngeal fracture. The fracture occurred in March 2017, which was after the decline in swallowing function already was noted, so causation of the decline could not be attributed solely to the laryngeal fracture.
- On 7/22/16, 11/19/16 and 4/16/17, Individual #134 had aspiration pneumonia, but the PNMT did not conduct a review or assessment. Individual #134 was referred to the PNMT for weight.

  In its comments on the draft report, the State questioned the finding that Individual #134 was not referred to or reviewed by the PNMT in response to a qualifying event. However, in the documents the State referenced, which the Monitoring Team reviewed for a second time, no evidence was present of a referral to the PNMT for Individual #134's aspiration pneumonia events, even though she was referred for other qualifying events.
- Individual #92 was referred to the PNMT for weight issues, and was referred to the PNMT numerous other times. Between 3/17/17 and 3/28/17, the PNMT conducted an assessment. However, prior to this, Individual #92 had multiple pneumonias, including a diagnosis of aspiration pneumonia on 1/13/17. In an IPN, the PNMT stated that criterion was not met due to aspiration pneumonia occurring at the hospital, but this decision was not consistent with policy, which states that the PNMT should at least review any diagnosis of aspiration pneumonia.

  In its comments on the draft report, the State questioned the finding that Individual #92 was not referred to or reviewed by the PNMT in response to a qualifying event. However, in the documents the State referenced, which the Monitoring Team reviewed for a second time, no evidence was present of a referral to the PNMT for Individual #92's aspiration pneumonia on 1/13/17. Moreover, as referenced above, the IPN that the PNMT RN wrote did not constitute a PNMT review. As stated in the draft report, Individual #92 was not referred for the January pneumonia, and the PNMT did not conduct a comprehensive assessment to address the aspiration pneumonia, until after Individual #92 had a second pneumonia event a little over a month later.
- Between December 2016 and March 2017, Individual #269 fell nine fell nine times. However, her IDT did not refer her to the PNMT, and the PNMT did not make a self-referral.
- On 10/10/16, Individual #349 was diagnosed with pneumonia as well as having multiple falls, but the PNMT did not conduct a review. Minutes from the PNMT stated that the PNMT SLP attended the ISP meeting and all supports and services were appropriate, but no detail was provided regarding what these supports were and how they were determined to be sufficient.

Based on review of the PNMT minutes, the individual's falls were not discussed.

In addition, Individual #349 was not referred to the PNMT to address unresolved falls. Criterion for referral is when an individual has three or more falls for two consecutive months. Between December 2016 and March 2017, criterion was met three times, but the IDT did not hold an ISPA meeting with the PNMT to discuss his falls.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, integrated progress reports with data and analysis of the data were not available to IDTs. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	15% 2/13	0/2	0/2	0/2	0/1	0/1	N/A	1/2	1/1	0/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	50% 1/2	N/A	0/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCP for which documentation was found to confirm the implementation of the PNM action steps that were included was for weight for Individual #92.

b. The following provide examples of findings related to IDTs' responses to changes in individuals' PNM status:

- Since January 2017, Individual #313 had a declining ability to swallow safely. In January 2017, a dysphagia assessment recommended a ground texture diet with thin liquids. By March 2017, it was recommended he receive NPO, followed by a recommendation for a pureed texture diet with nectar-thick liquids. In May 2017, he had another MBSS that recommended NPO again. His IDT decided to continue to allow him to eat by mouth. However, despite agreeing to a diet that went against the recommendations of the May 2017 MBSS, the IDT did not put in place additional training or monitoring.

- Individual #433's IDT did not develop an IHCP for falls despite the fact that they rated him as being at high risk.
- Numerous IDTs did not identify the underlying causes(s) of individuals' medium and high risk physical and nutritional management concerns, and/or develop plans to address them.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	42% 29/69	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	50% 2/4	
Comments: a. The Monitoring Team conducted 69 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 19 out of 42 observations (45%). Staff followed individuals' dining plans during 10 out of 26 mealtime observations (38%). Staff completed zero out of one (0%) transfers correctly.			

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/2		N/A	0/1					0/1	
Comments: a. As discussed above, Individual #92 did not have a measurable plan, even to reconsider his ability to return to oral intake. Although Individual #507 had a measurable objective, it was unclear how the IDT determined what the objective would be. Moreover, no evidence was found of data or analysis of data to determine her progress.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.

Summary: For the individuals reviewed, IDTs overall did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	33% 3/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The goals/objectives that were clinically relevant and achievable, but not measurable were those for Individual #255 (i.e., increased safety awareness with her walker), Individual #433 (increased shoulder flexion), and Individual #349 (i.e., ambulation). A number of individuals had OT/PT needs that were not addressed through goals/objectives and sufficient justification was not documented for not developing formal OT/PT services and supports. A few examples included:

- Individual #313 had upper extremity limitations as well as osteoporosis, but programs to address these needs were not developed (e.g., therapeutic standing program, upper extremity exercises).
- Individual #134 was dependent on staff for all ADLs and had an unsteady gait. No programs were developed and the OT/PT did not provide sufficient justification for not developing programs.
- Individual #269 had a history of falls and recently had 12 falls within a three-month period. The OT/PT assessment identified poor safety awareness (i.e., not looking down when walking) and fluctuating gait as contributing to the falls, but no program was developed to improve awareness and/or gait consistency.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports with data and analysis of the data were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	44% 4/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. For the individuals that scored positively on this indicator, evidence was found in the OT/PT IPNs. b. In November 2016, it appeared Individual #349 was discharged from direct PT therapy. However, his IDT did not hold an ISPA meeting to discuss the termination of therapy.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.										
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. In addition, the Center should take steps to ensure individuals' adaptive equipment is consistently clean. The related indicator was moved to less oversight, but during this review, for approximately 15% of the adaptive equipment observed, a lack of cleanliness was a problem. Failure to correct this problem could result in Indicator a moving back to active monitoring. [**Note:** due to the number of individuals reviewed for this indicator, scores continue below, but the totals are listed under "overall score."]			Individuals:							
#	Indicator	Overall Score	218	636	739	134	167	713	362	308	485
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									

b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	86% 32/37	1/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1
		Individuals:									
#	Indicator		186	310	83	670	785	441	424	466	66
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		373	19	781	255	290	312	366	45	612
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	2/2	1/1	1/1	1/1	1/2	1/1
		Individuals:									
#	Indicator		738	55	169	752	100	352	764		
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	0/1	1/1	1/1	1/1	2/2		
Comments: c. The Monitoring Team conducted observations of 37 pieces of adaptive equipment. Based on observation of Individual #134, Individual #308, Individual #45, and Individual #169 in their wheelchairs, the outcome was that they were not positioned correctly. In addition, Individual #167's was observed in a recliner lying sideways without bolsters to provide support. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.											

Domain #4: Individuals in the Target Population will engage in meaningful activities, through participation in active treatment, community activities, work and/or educational opportunities, and social relationships consistent with their individual support plan.

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition, dental refusals, and communication. None of the indicators had sustained high performance scores sufficient to be moved the category of requiring less oversight.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

In order to comment on the progress and management of ISPs, implementation and data are required. Given the amount of work that goes into preparing for the ISP and developing goals and action plans, implementation and data/documentation are priorities for Denton SSLC.

It was positive that many staff knew the preferences of individuals.

Regarding skill acquisition programs (SAPs), action steps were not regularly implemented for any individuals. In addition, when they were implemented, data were collected, but they were not data that were reliable. Thus, progress could not be determined. In those cases when there was a SAP for which the facility indicated progress, goals were not updated or introduced and, similarly, when the facility indicated no progress, no actions were taken.

SAPs were missing many components; none had all of the required components, including the absence of clear instructions for staff as to how to implement the plan as well as positive consequences for correct responding.

There were some good examples observed of individuals engaged in activities and of staff supporting their active engagement. It was also good to see that the facility was measuring engagement regularly and had set goals for all day and treatment sites. The next step is to achieve those goals.

Denton SSLC was involved with individuals' public school programs. To meet criteria, Denton SSLC will need to do a little bit more, that is, to participate in the IEP and develop action plans in the ISP to support individuals' IEPs.

For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals.

Although all nine individuals reviewed had communication and/or cognitive functioning deficits (e.g., problem-solving), as well as strengths upon which communication programs could be built, none of them had communication goals/objectives. It also was

concerning that based on observations, often individuals' AAC devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. The Center should focus on improvements in these areas.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Implementation and data are required if this set of indicators is to be determined. Given the amount of work that goes into preparing for the ISP and developing goals and action plans, implementation and data/documentation are priorities for Denton SSLC. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	173	313	134	269	255			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: As Denton SSLC further develops individualized personal goals, it should focus on developing actions plans that clearly support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators. Examples of how this might be accomplished are provided above.

4-7. A personal goal that meets criterion for outcomes 1 through 3 is a pre-requisite for evaluating whether progress has been made. None of the personal goals met criterion for Indicators 1 through 3 as described above. There was no basis for assessing progress for the other goals as the IDTs failed to develop personal goals that were also measurable. The Monitoring Team found the lack of implementation, monitoring, and reliable and valid data to be significant concerns.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	109	173	313	134	269	255			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. It was positive that many staff knew the preferences of individuals. Staff knowledge regarding individuals' ISPs, however, was insufficient to ensure its implementation, based on observations, interviews, and lack of consistent implementation.

40. Action steps were not consistently implemented for any individuals, as documented elsewhere in this section and throughout this report. Further, the QIDP Monthly Reviews had not tracked implementation, much less progress, of Individual #134's current ISP goals and action plans since her ISP was held in November 2016.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: SAPs did not have reliable data so that progress could be determined. In those cases when there was a SAP for which the facility indicated progress, goals were not updated or introduced and, similarly, when the facility indicated no progress, no actions were taken. All that being said, facility staff were collecting data. These four indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
6	The individual is progressing on his/her SAPS	0% 0/24	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	N/A
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/24	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	N/A
8	If the individual was not making progress, actions were taken.	0% 0/15	0/2	N/A	0/1	0/2	0/2	0/3	0/2	0/3	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	88% 21/24	3/3	3/3	3/3	3/3	3/3	3/3	3/3	0/3	N/A

Comments:
6. The data for nine SAPs indicated the individual was making progress or had mastered the current step. However, due to the lack of confidence in the data, none of the SAPs were rated as progressing.

7. The data for two SAPs (Individual #459 - computer use, and Individual #202 - dressing) suggested that the individual had met the goal and/or current step. There was no evidence that a new or updated goal had been introduced.

8. There was no evidence that action steps had been taken to address SAPs in which the individual was not making progress.

9. Data were available for 21 of 24 SAPs. Data were not consistently reviewed for any of Individual #134's three SAPs. Individual #630's SAPs were excluded from this calculation as her ISP had been held two months before the onsite visit and these SAPs had just recently been introduced.

Outcome 4- All individuals have SAPs that contain the required components.

Summary: SAPs were missing many components; none had all of the required components, including the absence of clear instructions for staff as to how to implement the plan as well as positive consequences for correct responding. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
13	The individual's SAPs are complete.	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:

13. None of the SAPs were considered complete. The most often occurring problems were:
    - the lack of teaching schedules that included the number of trials,
    - specific instructions related to teaching the identified skill, and
    - the use of individualized positive reinforcement.

Regarding the last bulleted item, the consequence for correct responding was often solely verbal praise. As the function of praise as a reinforcer is often dependent upon the person delivering the praise, this is not likely to be effective in teaching new skills.

Plans for generalization often were limited to using different instructors, something that is likely to occur during the acquisition phase of the SAP.

Outcome 5- SAPs are implemented with integrity.

Summary: There had not been improvement in the quality of implementation of SAPs or in a system to ensure this (though a plan was recently put in place, to be evaluated at the next onsite review). Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
14	SAPs are implemented as written.	17% 1/6	1/1	0/1	N/A	N/A	0/1	N/A	0/1	0/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

	achieved.										

Comments:
14. During the onsite visit, observations of training on one SAP were completed for six individuals. The exceptions were due to the SAP being implemented prior to the arrival of the Monitoring Team (Individual #459), or the individual's refusal to complete the SAP (Individual #240) or attend the program (Individual #202). Only Individual #333's SAP was completed as written. For all others, the reinforcer was not delivered as outlined (Individual #109, Individual #630), or the instructor provided verbal instructions that were not outlined in the SAP (Individual #173, Individual #313, Individual #134). Staff are advised to periodically probe the final step or terminal objective of the SAP as several individuals appeared to have mastered the skill (Individual #333, Individual #109, Individual #459, Individual #173).

15. The facility had just initiated assessment of SAP integrity in January 2017. Program managers were to assess two SAPs each month in each of the vocational or life skills areas. The QIDP was responsible for assessing integrity on SAPs in the individuals' homes.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.

Summary: Performance decreased for indicator 16 and increased for indicator 17. The presence of graphic summaries of SAP performance sets the occasion for monthly reviews based upon data (though those data need to be reliably collected [indicator 5]. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 333	109	459	240	173	202	313	134	630
16	There is evidence that SAPs are reviewed monthly.	42% 10/24	1/3	0/3	2/3	3/3	3/3	0/3	1/3	0/3	N/A
17	SAP outcomes are graphed.	89% 24/27	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	0/3

Comments:
16. Monthly QIDP reports were reviewed for each of the nine individuals. There was evidence that SAPs were reviewed monthly for 10 of 24 SAPs. Individual #630's SAPs were excluded from this analysis due to their having recently been implemented. The major problem included data based reviews in only some of the reports provided. In Individual #202's case, a data-based review was provided for a morning hygiene routine, but this did not match his SAPs for dressing and showering.

17. Graphs depicting SAP progress were provided for eight of the nine individuals. The exception was Individual #630 whose SAPs had just recently been implemented, but for whom graphs were not created.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: There were some good examples observed of individuals engaged in activities and of staff supporting their active engagement. It was also good to see that the facility was measuring engagement regularly and had set goals for all day and treatment sites. These two indicators (19, 20) had risen to, and maintained 100% scores, respectively. The next step is to achieve those goals, which would reflect as higher scoring on indicators 18 and 21. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	1/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	22% 2/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments:

18. Four of the nine individuals (Individual #333, Individual #109, Individual #459, Individual #202) were observed to be meaningfully engaged during the onsite visit. It was encouraging to observe a number of staff who were working with Individual #333 and Individual #109 taking the time to engage in incidental teaching of bed making and money skills, respectively. Staff are advised to reference life skills classes as day program or some term rather than workshops. Workshops imply that the individual is involved with vocational services. This is misleading because several individuals of working age (e.g., Individual #240) were not learning any kind of employment skills.

19-20. The facility had three quality assurance auditors who conducted engagement assessments each month across all homes and day program sites. In the two large day program sites (ICD and ETC), the auditor chose two rooms to assess each month. The goal across all sites was 65% engagement.

21. The facility's goal levels of engagement were achieved in the home and day program sites for two of the individuals, Individual #459 and Individual #202. These scores did not necessarily reflect the individual's specific level of engagement, but rather the engagement of those individuals who were present at the time of the assessment. For the remaining seven individuals, the average engagement score across six months ranged between 25% (Individual #333) and 63% (Individual #109).

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: These indicators were not met, indicating that more attention needs to be paid to individuals having opportunities for community outings and for training and learning of new skills in the community. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	333	109	459	240	173	202	313	134	630
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 22. None of the nine individuals met their goal frequencies for community recreational activities over a six-month period. 23. None of the individuals had goal frequencies of community-based SAP training identified in their ISPs. There was evidence of community-based training on one SAP for Individual #109 only. It should be noted that, with the exception of one day, the days of training did not match his identified community outing days. 24. There was no evidence of teams considering the barriers to individuals meeting their community recreational goals.											

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: It was good to see that Denton SSLC was involved with individuals' public school programs. To meet criteria for the set of sub-indicators, Denton SSLC will need to do a little bit more, that is, to participate in the IEP and develop action plans in the ISP to support individuals' IEPs. This is the same feedback given in the last report, indicating that no attention was paid to this for the small number of individuals to whom educational services are provided by the local independent public school district. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	468								
25	The student receives educational services that are integrated with the ISP.	0% 0/1	0/1								
Comments:											

25. At the time of the onsite visit, the facility identified two individuals who were scheduled to attend school in the fall. One of these individuals, Individual #468 was chosen for review of this outcome measure. There was evidence that he was attending school and that consideration had been given to inclusion and an extended school year. His IEP objectives were included in his ISP and his monthly QIDP reviews commented on his progress in school. All of this was good to see.

The facility's social worker attended his IEP meeting, but there was no evidence that his QIDP or other IDT members participated. There were no identified action plans in his ISP that supported his public school program.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 313	134	92	186	269	255	433	507	349
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5	0/1	0/1	N/A	0/1	N/A	0/1	N/A	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/5	0/1	0/1		0/1		0/1		0/1	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/5	0/1	0/1		0/1		0/1		0/1	
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/5	0/1	0/1		0/1		0/1		0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5	0/1	0/1		0/1		0/1		0/1	

Comments: a. through e. For four of the five individuals that had refused dental services or for whom documentation was unclear whether refusals contributed to many missed appointments (i.e., Individual #507), IDTs had not developed specific goals/objectives related to their refusals. Although Individual #313's IDT had developed a goal, it did not address the underlying cause of the dental refusals.

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Although all nine individuals reviewed had communication and/or cognitive functioning deficits (e.g., problem-solving), as well as strengths upon which communication programs could be built, none of them had communication goals/objectives. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. Although all nine individuals reviewed had communication and/or cognitive functioning deficits (e.g., problem-solving), as well as strengths upon which communication programs could be built, none of them had communication goals/objectives. c. For the nine individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals.											

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	313	134	92	186	269	255	433	507	349
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. Based on review of documents provided, the communication supports are not tracked or reviewed for effectiveness.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	283	153	746	209	73	440	111	513	32
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	44% 4/9	0/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/4									
Comments: a. and b. It was concerning that often individuals' AAC devices often were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.											

Domain #5: Individuals in the Target Population who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and will transition to the most integrated setting(s) to meet their appropriately identified needs, consistent with their informed choice.

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. This is only the second round of reviews in which the Monitoring Team reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, early in 2016, the Center began additional post-move monitoring responsibilities, and had begun to follow individuals in the community for a year as opposed to 90 days.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Some good progress was noted, but more work was needed to make supports in the CLDPs measurable, particularly pre-move training supports. The Center had standardized a core set of supports for inclusion in all CLDPs (such as bowel management) as a means of ensuring many needs were addressed. This was a good first step, but a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff.

It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. The Center should focus on the PMM basing decisions about supports on reliable and valid data, the PMM providing clear documentation to substantiate the findings, and IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports.

One individual reviewed experienced a potentially disrupted community transition (PDCT) event. For this individual, there were failures to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring. The IDT did not develop a full list of necessary supports to reduce the likelihood of negative events recurring.

It was positive to see the involvement of IDT members in the transition planning processes, review of the CLDP with the individuals and/or their guardians, and involvement of Local Authority staff in transition activities. Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. Some work was underway to improve the quality of transition assessments, which was good to see. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.

Summary: The Center made some progress in the development of pre-move training supports as well as in the measurability of many post-move supports, which was good to see. The IDTs should focus considerable attention on the development and implementation of pre-move training supports. The Center had standardized a core set of supports for inclusion in all CLDPs (such as bowel management) as a means of ensuring many needs were addressed. This was a good first step, but IDTs, with the assistance of the transition staff, still need to develop more comprehensive and individualized supports to address individuals' behavioral and psychiatric history and needs as well as their safety, medical, healthcare, therapeutic, risk, and supervision needs. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 142	68							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: 1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. For these two CLDPs, the Monitoring Team noted good progress since the previous report, but supports still did not consistently provide the Post-Move Monitor with measurable criteria or indicators that could be used to ensure supports were being provided as needed. In particular, the IDTs needed to focus considerable attention on the development and implementation of pre-move training supports. It is essential for the Center to be able to objectively verify provider staff competence to implement all important health and safety supports prior to individuals' moves to the community. Examples of supports that met criterion and those that did not meet criterion are provided below.

- The IDT developed eight pre-move supports for Individual #142 and twelve for Individual #68.
  - Both CLDPs included a doctor-to-doctor consult between the Center primary care provider (PCP) and the community provider, and both supports included specific information that was to be shared. This was positive.
  - Both CLDPs included pre-move training supports. The IDT for Individual #68 provided significantly more information as to the expectations for the training and how competency would be measured. Since his CLDP was approximately four months after Individual #142's, this could represent a general process improvement.
    - Individual #142's supports in this area did not consistently include either the specific requirements of the training and/or the criteria by which provider staff would demonstrate competency to provide the supports. For example, two pre-move training supports included in-service to the provider nurse for six current nursing problems and a behavioral in-service to cover prevention and management of problem behaviors as well as

training on general preventative techniques and replacement behaviors. The nursing in-service support did provide some detail regarding the expectations for what the training would include, although it did not indicate what would constitute competence. The behavioral support provided even less specificity. These two supports defined the required evidence as a review of the in-service and signature sheet. Neither specified how staff knowledge and/or competency would be measured. A signature sheet would not suffice, as that would only measure attendance. A third support indicated the Center dietitian would provide information regarding a specific set of dietary requirements related to his renal and fluid restrictions. The latter support did not state this would occur as an in-service or specify competency criteria, but it did require staff interview and observation as evidence. None of the three indicated the training methodology.

- Individual #68's pre-move training supports for nursing, the PNMP and the individual's psychiatric support needs all provided some level of specificity. The best example of the three was for psychiatric needs, because it outlined the specific symptoms, prevention, and management techniques provider staff needed to know. The former two supports listed topics to be covered, but did not include the same level of detail. For the nursing training support, the "evidence required" column did indicate the provider nurse would be interviewed regarding Individual #68's risk factors and active problem list, the purpose of medications, and possible side effects. This was an improvement, but did not clarify what the provider nurse would be expected to know about his various risk factors.
- Similarly, Individual #68's training support for the PNMP indicated how staff competence would be verified in modifying diet texture, the use and purpose of eating and adaptive equipment, how to administer medications and perform oral hygiene, which was positive. It did not specify criteria or methodology for measuring competency for the other topics, including mobility, transfers, bathing safety, and communication/sensory needs.
- It was encouraging to see that Individual #68's PNMP and psychiatric pre-move training supports specified some staff training methodologies. For example, the PNMP support called for provider staff to be observed modifying food to the correct diet texture. The psychiatric training support included a requirement for modeling and role-playing of prevention and management techniques.

- The respective IDTs developed 48 post-move supports for Individual #142, and 41 post-move supports for Individual #68. Both CLDPs included many measurable supports, especially related to arranging for medical appointments and consultations, laboratory testing requirements, and provision of equipment and materials by the Center for use at the community home. Other examples of measurable supports included:
  - For both individuals, the CLDPs included supports for specific diets that were measurable.
  - For Individual #142, the CLDP included supports for enrolling at a transitional skills program within 14 days of transition, and scheduling an appointment for a Department of Assistive and Rehabilitation Services (DARS) assessment within seven days. Both provided for specific documents to be reviewed as evidence.
  - For Individual #68, the CLDP included a support to follow his dining instructions as outlined in his PNMP and further specified instructions for how to assist him to eat, as well as his diet texture, liquid consistency, and equipment used. The evidence required included observation and inspection of equipment to ensure all was in good condition and working order, interview of staff regarding the purpose of all equipment and knowledge of the dining plan instructions, interview of staff regarding any incidents of choking or aspiration, review of the daily log for any such

incidents, and meal observation.

- Examples of post-move supports that did not meet criterion for measurability included:
    - For Individual #142, the CLDP included a support calling for the provider to implement his current PBSP, and integrate it into his plan of care upon transition. It also called for the provider staff to collect behavioral data in a manner that was "conducive to their facility" that should be reviewed and evaluated "on a consistent basis." These lacked specific and measurable expectations.
    - Individual #68's CLDP largely included measurable post-move supports, which was positive. The IDT still needed to ensure this was a consistent approach. For example, the IDT used terminology like well-balanced and fiber-rich to describe his dietary needs.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place for this indicator to be scored as meeting criterion. The Center had standardized a core set of supports for inclusion in all CLDPs (such as bowel management) as a means of ensuring many needs were addressed. This was a good first step, but IDTs, with the assistance of the transition staff, still needed to develop more comprehensive and individualized supports to address individuals' behavioral and psychiatric history and needs, as well as their safety, medical, healthcare, therapeutic, risk, and supervision needs.

It was also positive the Center recently had become engaged in a pilot effort to use the 14-day post-referral meeting to begin developing a comprehensive set of individualized supports. The Monitoring Team observed a 14-day meeting while on-site. Overall, it was very positive, and it was especially good to see an IDT working with the Transition Specialist to identify preferences and strengths as well as needs that are essential to developing a thorough CLDP, but often are not written down. Starting to populate the CLDP early in the process will help IDTs identify sets of community supports and providers that meet individuals' preferences as well as needs. For this process to be successful, IDTs will need to ensure that all important IDT members for an individual are present at the 14-day meeting. At the meeting observed while on-site, participation did not include one or more direct support professionals, the primary care practitioner (PCP,) and the Behavioral Health Services and/or psychiatry staff for this individual with a long history of complex behavioral health needs.

For the two CLDPs reviewed, examples of supports the IDT did not address as needed included:

a. Past history, and recent and current behavioral and psychiatric problems: Supports did not sufficiently reflect past history, and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
    - The CLDP did not fully address the need for staff knowledge regarding Individual #142's behavioral and psychiatric history, such as his history of inappropriate sexual behavior, particularly with children. The IDT did not develop a specific support for staff knowledge of this history. A pre-move training support indicated staff would be trained on prevention and management of Individual #142's problem behaviors and a post-move support called for staff to implement his PBSP, but neither support called for specific staff knowledge of this history. As described further below, the CLDP did not include a supervision support to ensure staff had knowledge of this need.
    - The vocational assessment recommended that for any employment sought for Individual #142, the employer should be aware of his behavior management plan as well as his dislike of being told what to do in a work environment. The IDT did not integrate this into the CLDP supports.
    - For Individual #68, the CLDP did not fully address the need for staff knowledge regarding behavioral and psychiatric

history, such as his history of aggression, biting himself, and property destruction.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: Overall, the Center evidenced some progress in developing supports that addressed safety, medical, healthcare, therapeutic, risk, and supervision needs. As noted with regard to Indicator 1, the respective IDTs developed many supports to ensure medical/healthcare treatments and consultations were provided as needed and in a timely manner. Some supports also clearly indicated signs and symptoms that direct support staff needed to report to the nurse and the timeframes in which those reports should be made. Still, the respective IDTs did not develop comprehensive supports for some significant needs in these areas. Examples included:
   - Pre-move training supports did not clarify that direct support staff needed training to a specific level of competency for medical, healthcare, therapeutic, and risk needs. Post-move supports often identified actions staff were to take in these areas, but no pre-move verification of training, knowledge, or competency was required. It is incumbent on the IDTs to verify staff have knowledge of and display competence about these important needs on the first day of transition.
   - The CLDP supports did not provide specificity about Individual #142's required level of supervision while in the community. Per the CLDP narrative, Individual #142 required one-to-one supervision at the Center. The behavioral health narrative in the CLDP indicated he had a history of exposing himself in public and would leave a supervised area to engage in sexual acts with others. It further stated the provider had been chosen because it was staffed with two direct support professionals at all times, and that the provider was aware that staff must accompany Individual #142 at all times to ensure his safety and the safety of any children that might live in the neighborhood. The IDT did not develop specific supports describing these needs for supervision. It did include a support describing the need for enhanced supervision when he stayed overnight with his family, where young children resided, but needed to address all his supervision needs in all settings.
   - The IDT for Individual #68 did not include a supervision support, nor did it indicate whether he would require any level of therapeutic oversight, monitoring or evaluation related to his dining needs/risks for aspiration and choking.

c. What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team noted the IDTs for both individuals cited essentially the same broad important outcomes and related personal goals in three out of four instances. These three outcomes included: 1) to increase independence in daily living skills, 2) to go on an increased number of community outings, and 3) to maintain the best physical health possible. The respective IDTs cited a different fourth outcome for the two individuals, but these also were broadly stated. For Individual #142, the fourth outcome was to remain psychiatrically and behaviorally stable, while for Individual #68, it was to become more independent in his daily life. The IDTs should make an effort to individualize these outcomes, including referring to the preferences and personal goals identified in individuals' ISPs.

d. Need/desire for employment, and/or other meaningful day activities in integrated community settings:
   - For Individual #142, the vocational assessment indicated he needed full-time paid work, not in a vocational workshop. The related supports included the provider contacting DARS within seven days of transition to schedule an appointment for an evaluation, enrollment at a community skills transitional skills program within 14 days, and beginning work within seven days. This latter support also noted restrictions on lifting due to his dialysis fistula and on working around children due to his history of inappropriate sexual activity. Finally, a support addressed learning, among other things, how to find job postings to complete job applications and engage in the interview process. It was positive the IDT focused attention on his employment needs, but the CLDP supports still did not comprehensively address them. For example, the supports did not specify it was important for him to have full-time paid work or

describe any expectation this outcome would be achieved. Supports also did not address the need for an employer to be aware of his behavioral or supervision needs in a work setting.
    - For Individual #68, a CLDP support called for the provider to ensure he was enrolled in and begin a day habilitation program within seven days of his transition. Additional supports provided examples of skills and activities with which the provider would provide encouragement, assist to obtain, and provide opportunities for participation. The IDT also included some examples of community activities, such as attending a festival, theme park or fair, or going on community outings where he could people watch, but these supports did not combine to reflect substantial opportunity to participate in meaningful day activities in integrated community settings. In developing such supports, the IDT needed to examine the meaningfulness of the activities, based on his preferences and strengths, the frequency of opportunity for participation, and the degree to which the settings offered opportunity for integration.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success: One of two CLDPs did address positive reinforcement, incentives, and/or other motivating components. The psychiatric support for Individual #68 described prevention and management strategies that included positive activities staff could implement that would help prevent and/or diminish psychiatric symptoms of repetitive body movement and aggression. The behavioral supports for Individual #142 did not specify any such strategies.
f. Teaching, maintenance, participation, and acquisition of specific skills: Both CLDPs included supports for skill acquisition and maintenance.
g. All recommendations from assessments are included, or if not, there is a rationale provided: The Center had a process for reviewing CLDP assessments, documenting discussion, and making final recommendations. Examples of recommendations made but not addressed or otherwise justified for exclusion included:
    - The vocational assessment for Individual #142 included recommendations that he be provided with full-time paid work, and that his employer be made aware of his behavioral needs in a work setting. The IDT did not integrate these in the CLDP employment supports.
    - For Individual #68, the habilitation therapy assessment recommended he receive occupational therapy/physical therapy (OT/PT) on a consultative basis. The CLDP narrative stated he did not currently receive direct OT/PT services, but could receive them in the community if he needed them. For Individual #68, who required ongoing support to address his risks related to aspiration and choking, as well as his mobility and positioning needs, it was unclear how his IDT determined that he did not require ongoing access to OT/PT professionals to complete monitoring of current supports and offer consultation to assess changing needs over time. Stating he did not receive direct services did not obviate his need for ongoing monitoring. At the very least, the IDT should have developed a support describing the frequency with which regular consults should be expected, as well as identified the issues, status changes, and other circumstances that would indicate a need for additional consultation and/or update.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. Some of the areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, the PMM providing clear documentation to substantiate the findings, and IDTs	Individuals:

following up in a timely and thorough manner when the PMM notes problems with the provision of supports. These indicators will remain in active oversight.											
#	Indicator	Overall Score	142	68							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's assessment is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A							

Comments: 3. Post-move monitoring had been completed for the seven-day, 45-day, 90-day, and 180-day PMM periods for Individual #142. The PMM completed each of these post-move monitoring visits in the proper format and in a timely manner. For Individual #68, the PMM made both the seven and 45-day visits on a timely basis. It was positive to see the PMM had made additional pop-in visits for Individual #68 between required monitoring.

4. The PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports in some instances, but there were issues that compromised reliability and validity. For both individuals, the PMM provided comments regarding the provision of most supports, but improvements to this documentation process were needed, as described below and throughout the comments for this indicator:

- Individual #142's CLDP included a support to begin work within seven days. The PMM documented he was attending a day habilitation program, but provided no documentation as to why he was attending such a program or when he began to do so.
- For some supports, the PMM did not provide comments that addressed the full scope of its requirements. For example:
  - At the seven-day PMM visit for Individual #142, the PMM documented he went over current nursing problems with the host provider, who stated she was aware of his current nursing issues and that he had not had any related problems.

There were 12 specific risks included in the support, but the documentation did not make clear whether each of these was covered as needed.
    - At the time of the seven-day PMM visit, the PMM documented he interviewed the provider regarding Individual #68's support for transfer, mobility, and movement instructions as outlined in his PNMP. The comment observed the provider acknowledged her instructions were to follow the PNMP, but did not comment on whether she could cite any specific knowledge about those instructions. It would not be feasible for the provider to check the PNMP before assisting Individual #68 each time with bathing and toileting needs as well as for all transferring, movement, and mobility. As such, the PMM needed to test the provider's specific knowledge that Individual #68 has weak bones and right shoulder/joint issues and needed to be handled gently and with no forced movement.

In addition to the lack of complete comments, it was not always possible to ascertain for either individual whether reliable and valid data were present, due in part to a lack of specificity and measurability of some supports as described with regard to Indicator #1.

5. Based on information the Post-Move Monitor collected, neither individual had consistently received supports as needed.
- Individual #142 had not consistently received supports as listed and/or described in the CLDP. Examples included:
    - At the time of the seven day-PMM visit, staff at his home did not accurately describe when the provider nurse should be notified regarding episodes of diarrhea.
    - Neither home nor day program staff knew they were to track bowel movements.
    - Neither day staff nor home staff had knowledge of a number of his food restrictions.
    - Provider staff did not have knowledge of his fluid restriction related to his diagnosis of chronic kidney disease (CKD), or all signs and symptoms of anemia which required monitoring and reporting.
    - Day habilitation staff did not have knowledge of his behavior plan and home staff did not know his targeted behaviors.
- Individual #68 had not consistently received supports as listed and/or described in the CLDP. Examples included:
    - The seven-day PMM checklist did not provide evidence the Center and the provider weighed him on the day of transition as required.
    - At time of the seven-day PMM visit, provider staff had not completed the bowel management log.
    - Documentation for his PBSP was not available for review across three visits spanning the seven and 45-day PMM timeframes.

6. Based on the supports defined in the CLDP, some scoring was not accurate based upon the available evidence. Examples included:
- The CLDP for Individual #142 included a support to see a psychologist in his new home within seven days of transition. The PMM noted an appointment was scheduled for 9/23/16, which would have been within seven days, but other documentation indicated this did not occur until 9/30/16. The support was marked as in place.
- For Individual #68, the seven-day PMM Checklist did not provide clear evidence that he had been weighed as needed on the day of transition. The support requiring that indicated his current weight was 132 pounds. Another support required he be seen by a dietitian if he gained or lost in excess of five pounds. The PMM Checklist documented his weight as 138 pounds at the time of the seven-day visit, which should have then triggered a referral to a community dietitian. The support was marked as not applicable.

7. The Monitoring Team noted some good examples of follow-up. For example, the PMM identified a need for follow-up for Individual #68 related to behavioral issues and contacted the Denton SSLC Board-Certified Behavior Analyst (BCBA). In turn, the BCBA contacted the provider and gave technical assistance. Also, as noted above, the PMM made pop-in visits to follow up on some concerns for Individual #68. Both exemplified good follow-up practice, but this was not yet consistent. Examples of deficient practices included:

- The PMM did not accurately and consistently identify supports that were not being provided. Thus, follow-up needs were not identified as needed. For example, the concerns noted with regard to Indicators 5 and 6 should have prompted the PMM to identify needed follow-up.
- Per the evidence provided, the respective IDTs did not meet to consider important post-move issues and give the PMM guidance about how those should be addressed and resolved. For example, the Center did not provide any evidence the IDT met to consider why Individual #142 was attending a day habilitation program instead of working, especially in light of his statement that he did not want to attend when interviewed at the time of the seven-day PMM visit.

9 and 10. Due to the fact the Monitoring Team attended only part of the post-move monitoring visit for an individual that was not part of the review group, these indicators were not rated.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.

Summary: One individual experienced a PDCT event. For this individual, there were failures to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring. The IDT did not develop a full list of necessary supports to reduce the likelihood of negative events recurring. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	68							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	1/2 50%	0/1	1/1							

Comments: 11. Individual #142 experienced a PDCT event within the first 90 days after transition. On 12/15/16, law-enforcement personnel were called after staff gave Individual #142 a set of instructions at the day habilitation program that he did not follow. He then became engaged in an argument with the supervisor and made threatening statements. The supervisor then called police. The residential provider spoke with the police officers and told him that her staff were on the way to pick Individual #142 up for a dialysis appointment he could not miss and the police acquiesced. Following the event, the provider met with the program director of the day habilitation program to discuss the incident and was told Individual #142 had been terminated from the program.

The IDT indicated the problem was anticipated prior to the move and further that Individual #142 had a behavior plan that was

reviewed during the CLDP, for which the provider had twice been in-serviced. The IDT did consider that his lack of regular employment might have been played a part in this event, focusing its discussion on the fact the Legally Authorized Representative (LAR) had not signed consent for a DARS assessment because she was considering having Individual #142 move closer to her. Recommendations and follow-up needs identified were for the Local Intellectual and Developmental Disability Authority (LIDDA) service coordinator to follow up with the LAR to obtain consent for the DARS referral, and for the Denton SSLC Placement Coordinator (PC) and behavior specialist to schedule a time to visit Individual #142 the week of 12/19/16. The behavior specialist also requested the provider forward Individual #142's new behavior plan so he could review it prior to the visit. The Monitoring Team did not see documentation of follow-up to these recommendations.

One of the important purposes of the PDCT process is to critically analyze the Center's actions during and after transition and use this information for process improvement in future transitions. In this instance, the Center should have identified that the CLDP failed to develop supports from vocational recommendations including: 1) Individual #142 required full time paid employment, specifically not in a provider setting, such as a workshop, and 2) that any employer be informed about Individual #142's unwillingness to accept direction in addition to other behavioral needs. In addition to this lack of needed supports, the PMM process did not provide for thorough identification and follow-up related to employment and behavioral needs. For example:

- On 10/7/16, the PMM documented Individual #142 stated he was not happy with the day program and did not want to attend anymore. This was not listed as an area of concern requiring follow-up at that time.
- At the time of the seven-day PMM visit, documentation indicated the day program staff were not aware of the behavior plan, but no follow-up was documented. The Center did not provide documentation of training of day program staff.
- On 12/16/16, the PMM checklist indicated the DARS assessment had not yet been completed and there was no related comment provided at the time of the next PMM visit on 3/17/17.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.

Summary: It was positive to see the involvement of IDT members in the transition planning processes, review of the CLDP with the individuals and/or their guardians, and involvement of Local Authority staff in transition activities. Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. Some work was underway to improve the quality of transition assessments, which was good to see. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, and the training did not appear to meet the individual's needs. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	142	68							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a	0% 0/2	0/1	0/1							

	community setting.										
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	1/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	50% 1/2	0/1	1/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	50% 1/2	0/1	1/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments: 12. Assessments did not yet consistently meet criterion for this indicator, but transition staff had been working with disciplines to improve the content and recommendations of transition assessments and there was improvement noted. The Monitoring Team considers four sub-indicators when evaluating compliance.

- Assessments updated within 45 Days of transition: The Center did not review or update the Integrated Risk Rating Form (IRRF) for these individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process. For Individual #142, the behavioral health assessment was not completed within 45 days of transition, but the remainder were timely. For Individual #68, the IDT did not update the following assessments within 45 days: nursing and vision. The latter assessment was not provided for review. The annual medical assessment indicated a vision exam had been completed on 3/17/15 with follow-up to be completed in one year. Follow-up was needed, because he had a diagnosis of bilateral cataracts.

- Assessments provided a summary of relevant facts of the individual's stay at the Center: Assessments that were not available or updated had a negative impact on the scoring of this indicator for both individuals.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not consistently meet criterion for this indicator. Again, missing assessments factored into this determination, but even assessments that had been updated did not consistently provide recommendations to support transition.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not consistently address/focus on the new community home and day/work settings.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. Both CLDPs met criterion.

14. Center staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: The Monitoring Team requested and reviewed the training documentation, including the training and testing materials. Overall, training did not meet criterion for this indicator, as described below:

- Training supports did not consistently define what was to be included in the training, which staff needed to be trained, the training methodologies, or how competency would be measured. As described with regard to Indicator 1, the training supports for Individual #68 did have more detail about training content and methodology. This was a positive step, but the documentation did not include evidence that this detail was incorporated into the actual training.
- Training documentation did not provide any verification of staff competencies for either individual.
- Training was not consistently focused on what staff would need to do in the community setting. For example, for Individual #142, the PBSP training included an instruction for the Campus Coordinator to be called in the event of a certain target behavior. This would not apply to his new home or day program. To ensure recommended interventions will be meaningful and appropriate in the new settings, Center clinicians should consult with the provider prior to the transition and confirm the correct action to be taken. Modifications should then be made to supports, including programs or plans, such as PBSPs.

15. When necessary, Center staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The CLDP should provide a specific statement documenting the IDT's consideration of the need for any such collaboration, and include a corresponding support, as appropriate. It was positive the respective IDTs considered the needs for such collaboration. The CLDPs for both individuals included a doctor-to-doctor support that specified the topics that needed to be discussed. It was also positive Individual #142's IDT included a support for the Center nurse case manager to accompany the PMM on the 45-day PMM visit. As noted above with regard to Indicator 14, however, the pre-move behavioral health training for Individual #142 highlighted an additional need for pre-move consultation that should have been considered to ensure a successful transition.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results. Neither of the CLDPs met criterion.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. The CLDP should include a specific statement of the IDT's consideration of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that occurred and their results. For Individual #68, the transition log documented the host home provider visited Denton SSLC and shadowed his team throughout the day. This was a positive practice. Individual #142's CLDP documentation did not provide specific documentation of this consideration

18. LIDDA participation: This indicator met criterion. Staff from the respective LIDDAs gathered information for the Home and Community Services (HCS) enrollment packages and participated in both CLDPs. The CLDP for Individual #68 also documented the LIDDA assisted in obtaining transition assistance services to purchase various items for his new home in the community.

19. The Pre-Move Site Reviews (PMSR) were completed in a timely manner and indicated all supports were in place. For both individuals, due to the lack of comprehensive competency testing, the PMSR failed to document that provider staff had knowledge of important health and safety needs that should have been clearly in place at the time of transition.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: This indicator will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	142	68								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1								

Comments: 20. Individual #142 was referred on 10/7/15, and transitioned on 9/21/16. While the transition process exceeded 180 days, the Transition Log provided substantial detail about the transition process, which was helpful and provided justification for the additional time required.

Individual #68 was referred on 7/13/16, and transitioned on 1/11/17, which was within 180 days.

APPENDIX A – Interviews and Documents Reviewed

Interviews: Interviews were conducted of individuals, direct support professionals, nursing, medical, and therapy staff.

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, date of prior ISP, date current ISP was filed, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since the last review, with date of admission;
- Individuals transitioned to the community since the last review;
- Community referral list, as of most current date available;
- List of individuals who have died since the last review, including date of death, age at death, and cause(s) of death;
- List of individuals with an ISP meeting, or a ISP Preparation meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT in the past six months;
    - Individuals discharged by the PNMT in the past six months;
    - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube in the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - In the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
    - In the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - In the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - In the past six months, individuals who have experienced a fracture;
    - In the past six months, individuals who have had a fecal impaction or bowel obstruction;
    - Individuals' oral hygiene ratings;
    - Individuals receiving direct OT, PT, and/or speech services and focus of intervention;
    - Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received;
    - Individuals with PBSPs and replacement behaviors related to communication;

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
- In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- In the past six months, individuals with dental emergencies;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- In the past six months, individuals with adverse drug reactions, including date of discovery.

- Lists of:
  - Crisis intervention restraints.
  - Medical restraints.
  - Protective devices.
  - Any injuries to individuals that occurred during restraint.
  - DFPS cases.
  - All serious injuries.
  - All injuries from individual-to-individual aggression.
  - All serious incidents other than ANE and serious injuries.
  - Non-serious Injury Investigations (NSIs).
  - Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
    - Were reviewed by external peer review
    - Were reviewed by internal peer review
    - Were under age 22
  - Individuals who receive psychiatry services and their medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
  a. PNMT
  b. OT/PT and Speech

c. Medical
d. Nursing
e. Pharmacy
f. Dental

- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)
- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- Last two quarterly trend reports regarding allegations, incidents, and injuries.
- QAQI Council (or any committee that serves the equivalent function) minutes (and relevant attachments if any, such as the QA report) for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.
- The facility's own analysis of the set of restraint-related graphs prepared by state office for the Monitoring Team.
- The DADS report that lists staff (in alphabetical order please) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- A list of any individuals for whom you've eliminated the use of restraint over the past nine months.
- A copy of the Facility's guidelines for assessing engagement (include any forms used); and also include engagement scores for the past six months.
- Calendar-schedule of meetings that will occur during the week onsite.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months

- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- AVATAR Immunization Record
- Consents for immunizations
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Direct Support Professional Instruction Sheets, and documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- To show implementation of the individual's IHCP, any flow sheets or other associated documentation not already provided in previous requests
- Last six months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last three months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- For individuals that have been restrained (i.e., chemical or physical), the Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing, Administration of Chemical Restraint Consult and Review Form, Physician notification, and order for restraint
- Signature page (including date) of previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one's signature page here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary, including periodontal chart, and signature (including date) page of previous dental examination
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received medical and/or dental pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments

- For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment

- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.

- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual's transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
ADL	Adaptive living skills
AED	Antiepileptic Drug
AMA	Annual medical assessment
APC	Admissions and Placement Coordinator
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
CBC	Complete Blood Count
CDC	Centers for Disease Control
CDiff	Clostridium difficile
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CXR	Chest x-ray
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DOJ	Department of Justice
DSHS	Department of State Health Services
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ENT	Ear, Nose, Throat
FSA	Functional Skills Assessment
GERD	Gastroesophageal reflux disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin

HCS	Home and Community-based Services
HDL	High-density Lipoprotein
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IM	Intramuscular
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IV	Intravenous
LVN	Licensed Vocational Nurse
LTBI	Latent tuberculosis infection
MAR	Medication Administration Record
mg	milligrams
ml	milliliters
NMES	Neuromuscular Electrical Stimulation
NOO	Nursing Operations Officer
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PDCT	Potentially Disrupted Community Transition
PEG-tube	Percutaneous endoscopic gastrostomy tube
PEMA	Psychiatric Emergency Medication Administration
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation

QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RDH	Registered Dental Hygienist
RN	Registered Nurse
SAP	Skill Acquisition Program
SO	Service/Support Objective
SOTP	Sex Offender Treatment Program
SSLC	State Supported Living Center
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus